

PreventionWORKS!

Office of Minority Health
Resource Center
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Prevention Primer

**an
encyclopedia
of alcohol,
tobacco, and
other drug
prevention
terms**

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Substance Abuse and Mental Health Services Administration

A Message from the Acting Director

The Center for Substance Abuse Prevention (CSAP) was recently approached by an executive faced with a dilemma. Her high tech company was developing a sophisticated computer game to teach players about the prevention of alcohol, tobacco, and other drug problems. Players would gain points by interacting with the computer, answering questions about children of alcoholics, employee assistance programs, risk factors, and other prevention topics.

The problem was that the executive was an expert on computer games, but a newcomer to the prevention field. To prepare the question-and-answer portion of the game, she needed state-of-the-art prevention knowledge on a variety of subjects. And she needed it fast.

Unfortunately for the computer expert, *Prevention Primer* was not available then. But it is now. Through summaries and excerpts from CSAP monographs and other publications from CSAP's National Clearinghouse for Alcohol and Drug Information, *Prevention Primer* provides a brief history of prevention efforts as well as an overview of the issues, principles, and approaches that work best.

Prevention Primer is also for the seasoned prevention practitioner who wants topical updates. Much has been learned about preventing alcohol, tobacco, and other drug problems over the past decade. This publication presents current prevention information in an easy-to-use format.

Prevention Primer is a handy reference tool for prevention practitioners. Topics are listed in alphabetical order, so readers can quickly find areas of interest. Readers can scan the index or flip through the pages to find what they need to know fast.

Prevention Primer can be read quickly, understood easily, and applied immediately. I hope that this publication will be a valuable resource for all who work to prevent alcohol, tobacco, and other drug problems.

Vivian L. Smith, MSW
Acting Director
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Note: As of October 1, 1992, ADAMHA was reorganized. The Office for Substance Abuse Prevention (OSAP) became the Center for Substance Abuse Prevention (CSAP). To avoid confusion, "Center for Substance Abuse Prevention" and "CSAP" are used throughout this document rather than the former name.

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AOD prevention
public health model
prevention strategy
special populations
handbook



Please feel free to be a "copy cat," and make all the copies you want. You have our permission!

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Introduction

There is no single definition of prevention. However, there is general agreement among prevention researchers that the most effective approach to reducing alcohol, tobacco, and other drug problems is through a public health approach. Such an approach acknowledges the complexity of the interactions contributing to the development of problems. Public health is concerned with disease and early death as they occur in populations. Its goal is to apply strategies and programs to reduce rates of disease and early death among groups of people. Unlike clinical medicine, the focus of a public health approach is collective, not individual.

Another distinctive feature of public health is that it focuses on communities, not individuals, and incorporates the perspective that communities are more than just groups of people. A public health model stresses that problems arise through a reciprocal relationship among the agent, the host, and the environment.

In alcohol, tobacco, and other drug problems, the agent is the alcohol, tobacco, and/or other drug; the host is the individual user; and the environment is the social and physical context of alcohol, tobacco, and other drug use. Of particular importance to prevention are the environmental influences on alcohol, tobacco, and other drug use, especially for young people. *Prevention Primer* incorporates the principles of a public health approach to preventing alcohol, tobacco, and other drug problems in its summaries of issues and strategies.

The term "prevention practitioner" is used throughout *Prevention Primer* to emphasize that prevention requires collective action by concerned community members. Individuals with professional training and experience in alcohol, tobacco, and other drug prevention are an important part of community prevention efforts and are a valuable resource for communities. However, the success of prevention efforts requires community members to get involved and make changes.

"Prevention planner" is another term used to describe those involved with prevention efforts. Planning is an essential part of any successful prevention program, but planning is a prelude to action. Action is what community prevention efforts are all about. *Prevention Primer* is designed to give community members the basic information and resources they need to become successful prevention practitioners.

Each section of *Prevention Primer* includes a partial list of publications. These basic documents, more technical in nature than this *Prevention Primer*, cite studies or other evidence in support of the assertions and conclusions reported herein. Publications that include inventory numbers are available, at no charge, through the Center for Substance Abuse Prevention's National Clearinghouse for Alcohol and Drug Information at 1-800-729-6686.

Acronyms. Many organizations and agencies are concerned with alcohol, tobacco, and other drug problem prevention. And a great deal of legislation has been directed at responding to alcohol, tobacco, and other drug problems. Agencies and legislation are often referred to by acronyms. The following list of commonly used acronyms can assist prevention practitioners decipher the “alphabet soup” of the alcohol, tobacco, and other drug problem prevention field.

AA	Alcoholics Anonymous
AACD	American Association for Counseling and Development
AAMFT	American Association for Marriage and Family Therapy
ABA	American Bar Association
ACA	American Council on Alcoholism
ACAP	American Council on Alcohol Problems
ACCA	American College Counseling Association
ACHA	American College Health Association
ACDI	American Council for Drug Information
ACoA	Adult Children of Alcoholics
ACOG	American College of Obstetrics and Gynecology
ACPA	American College Personnel Association
ADA	Americans with Disabilities Act
ADFS	Alliance for a Drug Free Society
ADPA	Alcohol and Drug Problems Association of North America
ADAPT	America's Drug Abuse Prevention Team
ADMS	Alcohol, Drug Abuse, and Mental Health Services
AHA	American Hospital Association
AI	Advocacy Institute
AITI	American Indian Training Institute, Inc.
ALF	American Liver Foundation
ALA	American Lung Association
AMA	American Medical Association
AMERSA	Association for Medical Education and Research in Substance Abuse
AMHCA	American Mental Health Counselors Association
AMSA	American Medical Student Association/Foundation
AMSAODD	American Medical Society on Alcoholism and Other Drug Dependencies
ANA	Administration for Native Americans
APA	American Psychiatric Association
APA	American Psychological Association
APHA	American Public Health Association
ASAM	American Society of Addiction Medicine, Inc.
ASCA	American School Counselors Association
AYWC	American Youth Work Center
BABES	Beginning Alcohol and Addiction Basic Education Studies
BADD	Bartenders Against Drunk Driving
BATF	Bureau of Alcohol, Tobacco, and Firearms
BCA	Boys Clubs of America
BSA	Boy Scouts of America
BIA	Bureau of Indian Affairs
CADCA	Community Anti-Drug Coalitions of America
CASA	Center on Addiction and Substance Abuse
CDC	Centers for Disease Control and Prevention
COA	Children of Alcoholics

Acronyms

COAF	Children of Alcoholics Foundation
COSSMHO	National Coalition of Hispanic Health and Human Services Organizations
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
CSPI	Center for Science in the Public Interest
CYAP	Community Youth Activities Program
DARE	Drug Abuse Resistance Education
DCDCC	Drugs & Crime Data Center & Clearinghouse
DDRP	Drug Demand Reduction Program
DEA	Drug Enforcement Administration
DFSCA	Drug-Free Schools and Communities Act
DHHS	Department of Health and Human Services
DOD	Department of Defense
DoEd	Department of Education
DOT	Department of Transportation
DUI	Driving Under the Influence
DWI	Driving While Intoxicated
EAPA	Employee Assistance Professionals Association
EASNA	Employee Assistance Society of North America
EIC	Entertainment Industries Council, Inc.
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FGP	Foster Grandparents Program
GFWC	General Federation of Women's Clubs
HUD	Department of Housing and Urban Development
IBCA	Institute on Black Chemical Abuse
ICAA	International Council on Alcohol and Addictions
ICPA	International Commission for the Prevention of Alcoholism and Drug Dependency
IHS	Indian Health Service
LCAT	Latino Council on Alcohol and Tobacco
MADD	Mothers Against Drunk Driving
NAADAC	National Association of Alcoholism and Drug Abuse Counselors
NAB-SAW	National Association of Black Substance Abuse Workers
NAC	National AIDS Clearinghouse
NAAPI	National Association of African Americans for Positive Imagery
NACoA	National Association for Children of Alcoholics
NACOP	National Association of Chiefs of Police
NADAP	National Association on Drug Abuse Problems, Inc.
NALSAP	National Association for Leadership in Student Assistance Programs
NAN	National Association of Neighborhoods
NANACOA	National Association of Native American Children of Alcoholics
NAPAFASA	National Asian Pacific American Families Against Substance Abuse, Inc.
NAPARE	National Association for Perinatal Addiction Research and Education
NAPPA	National Association of Prevention Professionals and Advocates, Inc.
NARMH	National Association for Rural Mental Health

NASADAD	National Association of State Alcohol and Drug Abuse Directors
NASBE	National Association of State Boards of Education
NASMHPD	National Association of State Mental Health Program Directors
NASW	National Association of Social Workers
NATI	National Association of Teen Institutes
NBAC	National Black Alcoholism/Addictions Council
NBCDI	National Black Child Development Institute
NCADD	National Council on Alcoholism and Drug Dependence
NCADD	National Commission Against Drunk Driving
NCADI	CSAP's National Clearinghouse for Alcohol and Drug Information
NCPA	National Committee for the Prevention of Alcoholism and Drug Dependency
NCPC	National Crime Prevention Council
NCJA	National Criminal Justice Association
NCJRS	National Criminal Justice Reference Service
NCY	National Collaboration for Youth
NEI	Narcotics Education, Inc.
NFIA	National Families in Action
NFP	National Federation of Parents for Drug-Free Youth
NGA	National Governors' Association
NHTSA	National Highway Traffic Safety Administration
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NMA	National Medical Association
NMF	National Masonic Foundation for the Prevention of Drug and Alcohol Abuse Among Children
NNSA	National Nurses Society on Addiction
NOFAS	National Organization for Fetal Alcohol Syndrome
NOSAPP	National Organization of Student Assistance Programs and Professionals
NPN	National Prevention Network
NRHA	National Rural Health Association
NRIADA	National Rural Institute on Alcohol and Drug Abuse
NSAPC	National Student Assistance Program Corp.
NSBA	National School Boards Association
NYSCA	National Youth Sports Coaches Association
OESE	Office of Elementary and Secondary Education
OJJDP	Office of Juvenile Justice and Delinquency Prevention
OJP	Office of Justice Programs
OMH	Office of Minority Health
ONDCP	Office of National Drug Control Policy
OPM	Office of Personnel Management
ORHP	Office of Rural Health Policy
PDFA	Partnership for a Drug-Free America
PIP	Partners in Prevention
PRIDE	Parents' Resource Institute for Drug Education, Inc.
PTA	National Congress of Parents and Teachers
RADAR	Regional Alcohol and Drug Awareness Resource Network
RIC	Rural Information Center
RID	Remove Intoxicated Drivers
RSA	Research Society on Alcoholism
RSVP	Retired Senior Volunteer Program

Acronyms

RWJ-FB	The Robert Wood Johnson Foundation's Fighting Back
SADD	Students Against Driving Drunk
SAFE	Solvent Abuse Foundation for Education
SALIS	Substance Abuse Librarians and Information Specialists
SAMHSA	Substance Abuse and Mental Health Services Administration
SAS	Student Assistance Services Corporation
SCP	Senior Champion Program
SDAP	Sports Drug Awareness Program
SGMA	Sporting Goods Manufacturers Association
SNAP	Sane National Alcohol Policy
SNC	Scott Newman Center
TEAM	Techniques of Effective Alcohol Management
TI	Teen Institute
USCG	United States Coast Guard
USIA	United States Information Agency
VA	Department of Veterans Affairs
VISTA	Volunteers in Service to America

REFERENCE

Citizen's Alcohol and Other Drug Prevention Directory. Resources for Getting Involved (1990) BK171

African-American Youth. Contrary to commonly held beliefs, use of alcohol and other drugs is low among urban African Americans under age 16 who stay in school. Although these youths tend to delay starting the use of alcohol and other drugs for a longer period of time (into their late to mid teens) than their White, Hispanic/Latino, and American Indian peers, they are at risk for developing heavy patterns of drug use by virtue of a number of negative environmental factors. Those factors include daily exposure to alcohol and other drugs, often at the hands of friends and family, and the lure of the drug trade and the drug culture that surrounds them.

The messages conveyed to young people are important factors affecting the community environment surrounding alcohol, tobacco, and other drug use. For example, inner-city communities are often targets of alcohol and tobacco promotional activities. In New York and Philadelphia, prevention activists like Reverend Calvin O. Butts and Reverend Jesse Brown have mobilized community protests against billboard advertising of alcohol and tobacco products. In Detroit, prevention activists like Alberta Tinsley-Williams were successful in removing billboard advertisements for a popular brand of rolling papers, often used for marijuana cigarettes, from African-American neighborhoods.

A key element of any prevention initiative is communicating messages that reflect social norms to promote healthy behaviors. *Communicating About Alcohol and Other Drugs: Strategies for Reaching Populations at Risk.* CSAP Monograph 5 makes recommendations for prevention strategies focused on African-American youth. They are:

1. *Encourage personal, one-on-one mentoring of young urban African Americans by positive role models.* Community-wide mass media campaigns could promote the positive benefits that can result from the involvement of African-American adults with youths as mentors and positive role models.
2. *Call attention to the need for improved parenting skills and reduced teen pregnancies.* With the proliferation of teenage pregnancy and poor single parent families, there is a need to challenge normative beliefs among young African Americans who consider getting pregnant at early ages as acceptable. Communications activities to address teenage pregnancy and improve parenting skills could include church-based parent training workshops and seminars; using drama such as plays, skits, and rap songs as ways to reach teens; television documentaries and town meetings to focus community attention on the importance and benefits of improved parenting; and television documentaries highlighting success stories about the adoption of African-American children.
3. *Encourage African-American churches to become involved.* The African-American church has a historical role in addressing social and political issues of the community. Provided with appropriate information and training about alcohol, tobacco, and other drugs, they can better identify strategies to address these problems within the context of the African-American spirituality.

4. *Communicate to more young African Americans their rich cultural heritage.* All prevention and treatment programs need to communicate the inherent dignity of each human being and, in the case of young urban African Americans, the rich cultural heritage they share with people of African ancestry all over the world.

5. *Persuade television program decision-makers to be more sensitive in their portrayals of African Americans.* Because much of alcohol and tobacco advertising is targeted specifically to African-American consumers, media strategies are needed to serve as countermeasures. Citizens concerned about the quantity and content of alcohol advertisements targeted at African Americans may want to write or call their local stations to complain and encourage airing counter messages and information about the adverse consequences of alcohol use, particularly for young people.

6. *Use African-American radio.* Urban areas often have several radio stations that target and reach African-American audiences. Popular activities that can be used include:

- Call-in talk shows;
- Locally produced public service announcements (PSAs);
- Disk jockeys who introduce issues, inform listeners, promote activities, and invite commentary; and
- Letters and telephone calls to station general managers, urging more attention to developing solutions to alcohol, tobacco, and other drug problems affecting the community, and highlighting the successes of youth in the community.

7. *Work with the business community, especially in high-density urban areas, to increase advertising for prevention messages.* A number of African-American organizations are beginning to focus on the issue of alcohol and tobacco advertising targeted to African Americans. These organizations have begun an appeal to the African-American media to rethink their ad content because of a concern about alcohol, tobacco, and other drug problems in the African-American community. While they recognize that alcohol and tobacco advertising is a major source of income for many African-American publications, they want to explore ways to replace alcohol ads with ads for other products.

8. *Mobilize local citizens to demand removal of offensive alcohol, tobacco, and other drug paraphernalia ads from billboards.* Studies have shown that there is a higher rate of alcohol and tobacco billboard advertising in inner-city neighborhoods. Some community leaders are seeking bans on such advertising. Counter-advertising on billboards can also be an effective strategy.

9. *Use media that involve youths.* Much creative talent can be found among African-American youth. Youths can contribute in meaningful ways to developing messages and communicating ideas through video documentaries, poster and rap contests, music videos, and plays and skits.

10. *Make information available where youths congregate.* Examples of such environments include:

- **Movie theaters:** Movie makers and theater owners can be encouraged to devote PSA space for alcohol, tobacco, and other drug prevention messages as lead-ins to feature presentations.
- **Recreation centers:** Many urban African-American youths frequent recreation centers, which are ideal places to distribute prevention materials.
- **Corner grocery stores:** Many inner-city neighborhoods are served by small family-operated grocery stores. Store owners can be enlisted to help distribute prevention materials.

11. *Encourage corporations to take a more active role in prevention efforts.* Some corporations are beginning to realize it is more cost effective to help urban African-American youths develop into productive adults than to face the enormous economic and social consequences of benign neglect. Communication strategies can be developed to increase the awareness of the benefits of helping these youths through programs like Adopt-A-School and Summer Jobs.

12. *Develop materials targeted to African-American youths.* Materials should feature African Americans in good visual materials including billboards, posters, and brochures. Materials developed should be culturally as well as age-appropriate. Where appropriate, low-literacy materials should be developed.

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- The Fact Is...Alcohol and Other Drug Use Is a Concern for African American Families and Communities* (1990) MS402
- "The Nation's Health: Special Populations" In *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. Washington, DC: Department of Health and Human Services (1991)
- Citizen's Action Handbook on Alcohol and Tobacco Billboard Advertising.* Washington, DC: Center for Science in the Public Interest (1990)
- Help for Inner-City Children of Addicted Parents.* New York: Children of Alcoholics Foundation (1993)

AIDS. The link between the human immunodeficiency virus (HIV), which causes AIDS, and intravenous drug use is well known. In addition, a 1991 report from the National Commission on AIDS said that the link between non-injectable substances, such as alcohol and crack, and unsafe sexual activity which can result in the spread of HIV, also has become glaringly evident.

Partying with alcohol and other drugs poses potentially deadly consequences for young people in the era of AIDS. Getting high can lead to unplanned or unprotected sex and infection with HIV. The National Institute on Drug Abuse targeted young adults in its ad campaign, "Get High, Get Stupid, Get AIDS," after its studies confirmed that many young adults use alcohol and other drugs to lose their inhibitions with members of the other sex, combining two high-risk behaviors for contracting HIV.

For prevention practitioners the challenge is to develop programs to reach those at risk for contracting HIV. The role of alcohol and other drug use in contributing to high risk sexual behavior is the focus of education campaigns directed at particular risk populations, including teenagers, young adults, and homosexuals. Teenagers and young adults are two of the most difficult and elusive audiences to reach with AIDS prevention messages. Research suggests that the relationship of alcohol and other drug use with sex may be different among young people than among adults, as adolescents and young adults may be novices at both drinking and sexual activity. As a result, their risky behavior may reflect the limited knowledge and experience of beginners in any endeavor.

By sharing infected needles intravenous drug users can spread HIV and risk infecting sexual partners. Outreach efforts to identify injected drug users and encourage them to enter treatment is an important part of AIDS prevention. A more controversial strategy is needle exchange programs designed to reduce risk of HIV transmission by providing injected drug users with clean needles. AIDS prevention is helped by general prevention efforts aimed at reducing levels of alcohol consumption and eliminating illicit drug use.

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Program Development for Community AIDS Outreach (1992) PHD571
NIDA Capsule: Fact's Supporting NIDA's Drug Abuse and AIDS Prevention Campaign for Teens (1990) CAP36
Voluntary HIV Counseling and Testing: Facts, Issues, and Answers. Rockville, MD: CDC's National AIDS Information Clearinghouse (1991)

Alternatives Approach. The alternatives approach is a commonly used prevention strategy. Studies indicate that programs providing opportunities for recognition and alcohol- and drug-free leisure activities are effective in changing alcohol, tobacco, and other drug use behaviors. Alternative programs have also been found to be successful with high-risk populations.

Often the attraction for young people is sports or free meals, not alcohol, tobacco, and other drug prevention activities. According to a report from the U.S. General Accounting Office, young people would rather believe—and have others believe—that they are participating in a community program or a recreation league rather than in an alcohol or other drug abuse prevention program. Participants are less attracted to a straightforward alcohol, tobacco, and other drug prevention program because they don't want to be labeled as having a problem.

Alternative programs include a wide range of activities to appeal to the diverse interests of children and youths, and may include athletics, art, music, movies, or community service projects. Activities need to be readily accessible and appropriate to the target population. For example, midnight basketball leagues in drug-plagued communities attract youths who would not necessarily participate in other, more conventionally scheduled, recreational activities.

Children, young people, adults, and families need opportunities to engage in alcohol- and other drug-free activities. Children who live in high risk communities need safe alternative environments in which to spend time, such as Boys Clubs or Girls Clubs. If the only peers they interact with use alcohol, tobacco, and other drugs, they may need opportunities to meet and develop relationships with new friends who do not. Youths need alternatives in their environments to experience and reinforce healthy behaviors.

REFERENCE

Turning Awareness Into Action: What Your Community Can Do About Drug Use in America (1991) PHD519

American Indians/Native Alaskans. While overall rates of alcohol and other drug use are high in American Indian/Native Alaskan groups, the prevalence varies tremendously from tribe to tribe and by age and sex within tribes. However, American Indians/Native Alaskans die more frequently than members of other ethnic/racial groups from suicide, homicide, and unintentional injuries or accidents, most of which are related to alcohol. These causes, along with cirrhosis of the liver and alcoholism, account for more than a third of all American Indian deaths. For this group as a whole, death rates from alcohol-related causes are more than three times higher than other groups.

Marijuana is the next most widely used drug after alcohol. It is estimated that about half (41 to 62 percent) of American Indian youths have tried marijuana, compared with less than half (28 to 50 percent) of other youths, although there is wide intertribal variation.

A task force convened by the U.S. Office for Minority Health reports that American Indians/Native Alaskans have had their traditional way of life disrupted, often resulting in a sense of powerlessness and hopelessness which may be related to the high incidence of alcohol and other drug problems in this population.

But American Indians/Native Alaskans also often draw upon traditional sources of strength to cope with stress, including the family, the tribe, and the land itself. As with other population groups, the use of culturally appropriate strategies is important for the success of prevention programs. It is also important to understand the diversity of American Indian/Native Alaskan tribes. In addition, as American Indian/Native Alaskan tribes are often sovereign political entities with specific powers of self-governance, it is important to include tribal leaders and other important community members in all phases of prevention initiatives.

Many groups on and off reservations are beginning to carry out alcohol and other drug prevention and intervention strategies that are community controlled and empowered. Unlike 10 years ago, there are now pow-wows, rodeos, and other gatherings at which alcohol and other drugs are expressly forbidden.

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- The Future by Design: A Community Framework for Preventing Alcohol and Other Drug Problems Through a Systems Approach* (1991) BK189

"The Nation's Health: Special Populations" In Healthy People 2000: National Health Promotion and Disease Prevention Objectives. Washington, DC: Department of Health and Human Services (1991)

Renewing Traditions: An Alcohol Prevention Program for Early Childhood American Indian Youth. Phoenix, AZ: Arizona Department of Education (1993)

American Indians/Native Alaskans

Asian/Pacific Islander Americans. The term Asian/Pacific Islander comprises more than 60 separate ethnic/racial groups and subgroups. These groups represent diverse populations in terms of their histories and experiences in the United States, languages and dialect, religions, cultures, socioeconomic status, and places of birth. There are also vast differences in the degree in which these groups are acculturated and assimilated into the mainstream culture. While alcohol and other drug use does not appear to be as extensive among the Asian/Pacific Islander population as it is in other population groups, there are significant differences in use and problems among the different ethnic/racial groups and subgroups.

Little research has been conducted on alcohol and other drug use among Asian/Pacific Islander Americans. Research that has been conducted suggests that numerous high-risk factors are common to both Asian and non-Asian youth. However, Asian youths and adults experience added personal, family, and social problems by virtue of their immigration status, economic stress, racism, and discrimination.

Prevention programs for Asian/Pacific Islander Americans will be most effective if they reflect the values and norms of the culture group being served. It is also important to understand how alcohol, tobacco, and other drugs are viewed, and used, within that culture. The cultural context approach to Asian/Pacific Islander Americans' alcohol, tobacco, and other drug use is the one most widely used by prevention practitioners. However, it has limitations in that it fails to account for the vast differences among these groups.

The National Asian Pacific American Families Against Substance Abuse, Inc. (NAPAFASA), a national umbrella organization, has been successful in drawing attention to alcohol and other drug problems in the Asian/Pacific Islander American population. NAPAFASA has implemented several CSAP community-based prevention efforts that provide important information on both the level of problems and promising strategies for prevention among this fast growing, diverse racial group.

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Binge Drinking. Binge drinking is defined as “the consumption of five or more drinks in a row on at least one occasion.” In national surveys about a third of high school seniors and 42 percent of college students reported at least one occasion of binge drinking within the previous 2 weeks.

While national surveys have documented a significant decline in the use of other drugs by high school seniors and college-age youths, there have been only modest declines in the numbers reporting binge drinking. Teenagers and young adults drink alcoholic beverages at about the same rates they did 5 years ago. Binge drinking increases the risk for alcohol-related injury, especially for young people, who often combine alcohol with other high risk activities, such as impaired driving. According to the Centers for Disease Control and Prevention, the four leading injury-related causes of death among youths under the age of 20 are motor vehicle crashes, homicides, suicides, and drowning. Alcohol is involved in many of these deaths.

Sexual encounters with their inherent risks of pregnancy, sexually transmitted diseases, and HIV exposure, as well as date rape and other violence, can and do occur more frequently while students are consuming large amounts of alcohol by binge drinking.

Binge drinking, or the partying lifestyle of young people, may be related to an environment that appears to support heavy drinking. Youths report that alcohol is more easily available to them today than it was 5 years ago, and there is a high correlation between availability and use. In addition, alcoholic beverages remain inexpensive in comparison with other beverages, especially beer when purchased in kegs, often the center of a party.

As young people enter the culture of the college campus, they are confronted with many challenges and opportunities: the opportunity to be independent of parental control; the need to conform; and the insecurity of a new social setting. Forty-one percent of college students engage in binge drinking, as compared to 34 percent of their non-college counterparts.

Another factor that may add to the college setting as a high-risk environment for binge drinking is that youths on college campuses are targets of heavy marketing of alcoholic beverages. Beer companies are especially active in promoting to college students. Student newspapers and campus bulletin boards boast ads for happy hours with price reductions and other incentives that promote heavy drinking. Representatives of the alcohol industry, including producers, wholesalers, and retailers, sponsor campus social, sporting, and cultural events, even on campuses where the majority of participants are under the age of 21.

Prevention strategies in response to binge drinking by young people include actions to reduce alcohol availability, such as increases in price, and responsible beverage service practices, especially at parties. Some communities require keg tagging, which requires kegs to be labeled with a serial number identifying the purchaser in case the keg is discovered at an underage drinking party. Other strategies include restrictions on marketing and promotion practices that glamorize heavy drinking, especially those directed at young people.

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Birth Defects and Adverse Birth Outcomes.

The safest choice for a pregnant woman is not to use alcohol, tobacco, and other drugs. To do otherwise can lead to birth defects or other adverse birth outcomes. Problems associated with alcohol, tobacco, and other drug use during pregnancy are well documented in the research literature. Alcohol, tobacco, and other drug-exposed infants are more likely to suffer from a greater range of medical problems and in some cases require costlier medical care. Most important, perinatal alcohol, tobacco, and other drug use exacts a high toll on families and communities.

About 1 out of every 10 newborns in the United States—375,000 per year—is exposed prenatally to one or more drugs. In major cities, many hospitals report that the percentage of newborns showing the effects of drugs is 20 percent or even higher.

Alcohol-Related Birth Defects

Babies whose mothers drink during pregnancy, especially those who drink heavily, may be born with fetal alcohol syndrome (FAS). As set by the Fetal Alcohol Study Groups of the Research Society on Alcoholism, the criteria for diagnosing FAS are: (1) weight and/or length below the 10th percentile; (2) central nervous system involvement, including neurological abnormalities, developmental delays, behavioral dysfunction, intellectual impairment, and skull or brain malformations; and (3) a characteristic face with short eye openings, a thin upper lip, an elongated, flattened midface, and a groove in the middle of the upper lip.

When only some of these criteria are met, the diagnosis is fetal alcohol effects (FAE). The harmful effects of prenatal exposure to alcohol are now known to exist on a continuum, ranging from full-blown FAS to mild FAE that may include more subtle cognitive and behavioral defects.

Mental disabilities and hyperactivity are probably the most debilitating aspects of FAS. Problems with learning, attention, memory, and problem solving are common, along with lack of coordination, impulsiveness, and speech and hearing impairment. Deficits in learning skills persist even into adolescence and adulthood.

FAS and FAE cost nearly a third of a billion dollars a year to treat and are among the leading known causes of mental retardation. Recorded cases of FAS more than tripled between 1979 and 1992, according to the Centers for Disease Control and Prevention. In 1979, about 1 in every 10,000 births involved FAS. By 1992, nearly 4 of every 10,000 births were diagnosed with FAS. Although the increase may be the result of better reporting by doctors, FAS may be even higher. The characteristic facial features are difficult to recognize in newborns, and mental retardation may not be identified until several years after birth.

Not all women who drink alcohol during pregnancy have babies with FAS or FAE. Variables affecting outcome include genetics, cigarette smoking and other drug use, nutrition, and time of use during pregnancy.

Unlike other known causes of mental retardation, FAS and FAE are totally preventable. Prevention efforts have focused on educating the public about the risks of consuming even small amounts of alcohol during pregnancy. In 1988 Congress passed a bill requiring warning labels on alcoholic beverage containers, including the risks of birth defects. Communities across the country have conducted education campaigns, and some require posting warning signs about the risk of alcohol-related birth defects at establishments where alcoholic beverages are sold.

Perinatal Tobacco Use

According to the U.S. Office on Smoking and Health, exposure to tobacco smoke poses grave risks to babies before and after they are born.

Spontaneous abortion, preterm births, low-weight full-term babies, and fetal and infant deaths all occur more frequently among mothers who smoke during their pregnancy. In addition, smoking in the presence of babies and young children places them at greater risk for health problems. Hospital admissions for bronchitis, pneumonia, and related illnesses occur twice as often for children whose parents smoke. The greater the exposure—two parents smoking rather than one—the greater the risk.

Tobacco control efforts across the country now focus on eliminating environmental tobacco smoke as well as preventing smoking initiation and promoting smoking cessation. Prevention strategies include education efforts, environmental controls on smoking, and restrictions on tobacco availability, including increased tobacco excise taxes in some States, and bans on cigarette vending machines in some communities.

Other Drug-Related Birth Defects

Approximately 11 percent of pregnant women use at least one of the following drugs: heroin, methadone, amphetamines, PCP, marijuana, and cocaine. Infants of drug users may go through drug withdrawal or have other medical problems at birth.

A national study conducted by the National Institute on Drug Abuse (NIDA) found that the average annual number of drug-affected newborns more than doubled from the time period 1982-84 to 1985-86, and nearly doubled again between 1985-86 and 1987. In all, there was a 339 percent increase in the average annual number of drug-affected newborns between 1979 and 1987. Approximately 38,000 drug-exposed babies were born in the United States in 1987.

Only about 1 in 10 (11 percent) of the 280,000 pregnant women in need of drug treatment in the United States receives such services, according to a survey conducted by the National Association of State Alcohol and Drug Abuse Directors (NASADAD). In response to the low rate of treatment, a White House publication reported "The need to increase the availability of treatment for pregnant women who use drugs, combined with the difficulty in persuading many such women to enter and remain in drug treatment, are

among the most persistent and troublesome problems in the treatment field."

Many treatment programs do not accept pregnant women or mothers and their infants. And according to a 1990 survey of 24 Pregnant and Postpartum Demonstration Projects funded by CSAP and conducted by the National Council on Alcoholism and Drug Dependence (NCADD), significant barriers to women seeking services included housing, transportation, and child care. Waiting lists are also cited in the literature as barriers to receiving services. Often women identified through prenatal assessments as needing services for alcohol, tobacco, and other drug problems must languish on waiting lists or run the gauntlet of an often daunting referral process before services are available.

Recent research studies reported that drug-exposed infants may develop poorly because of stress and chaos caused by the mother's drug use. These children experience double jeopardy. They often suffer from biological vulnerability due to prenatal drug exposure, which then may be exacerbated by poor caretaking and multiple separations due to the drug user's lifestyle. In contrast, drug exposed children who are nurtured in a warm, supportive environment are often able to develop well. The National Association for Perinatal Addiction Research and Education (NAPARE) calls for increased funding for prevention and treatment programs and health care systems to answer the needs of the highest risk populations.

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Blood Alcohol Concentration. Blood alcohol concentration (BAC) is the amount of alcohol in the bloodstream. It is measured in percentages. For instance, having a BAC of 0.10 percent means that a person has 1 part alcohol per 1,000 parts blood in the body.

In a review of studies of alcohol-related crashes, reaction time, tracking ability, concentrated attention ability, divided attention performance, information process capability, visual functions, perceptions, and psycho-motor performance, impairment in all these areas was significant at blood alcohol concentrations of 0.05 percent. Impairment first appeared in many of these important areas of performance at blood alcohol concentrations of 0.02 percent, substantially below the legal standard in most States for drunkenness, which is 0.10 percent.

Approximately half of traffic injuries involve alcohol. About one-third of fatally injured passengers and pedestrians have elevated blood alcohol levels. For fatal intentional injuries, half of homicides involve alcohol, as do one-quarter to one-third of suicides.

The Centers for Disease Control and Prevention (CDC) estimate that about 30,000 unintentional injury deaths per year are directly attributable to alcohol. Another 15,000 to 20,000 homicides or suicides per year are associated with alcohol.

For non-fatal unintentional injuries many studies show that 25 to 50 percent involve alcohol. The same rates are found for a wide range of non-fatal intentional injuries involving alcohol, including assaults, spouse abuse, child molestation, sexual assault, rape, and attempted suicide.

BAC can be measured by breath, blood, or urine tests. BAC measurement is especially important for determining the role of alcohol in crashes, falls, fires, crime, family violence, suicide, and other forms of intentional and unintentional injury. Information on BAC: (1) provides a baseline for evaluating prevention and intervention programs; (2) supplies data needed for planning and providing direct services; and (3) improves estimates of the economic costs of alcohol use.

One problem in obtaining accurate BAC data is a lack of testing in hospital emergency rooms. Research indicates that emergency rooms do not test routinely for alcohol in crash victims. A national survey of trauma centers found that although two-thirds of the centers estimated that the majority of patients had consumed alcohol, only 55 percent routinely conducted BAC tests at patient admissions. A review of emergency room studies indicated that up to one-third of patients admitted to emergency rooms are not tested.

BAC and Impaired Driving

The public most commonly associates BAC with drunk driving. However, it is more accurate to refer to alcohol-impaired driving because one does not have to be drunk (intoxicated) to be demonstrably impaired. Driving skills, especially judgment, are impaired in most people long before they exhibit

visible signs of drunkenness. While most States define legal intoxication for purposes of driving at a BAC of 0.10 percent or higher, alcohol may cause deterioration in driving skills at 0.05 percent or even lower. Deterioration progresses rapidly with rising BAC.

In recognition of impairment at lower BAC levels, the National Highway Traffic Safety Administration (NHTSA) refers to traffic crashes as “alcohol involved” or “alcohol related” when a participant (driver, pedestrian, or bicyclist) has a measured or estimated BAC of 0.01 or above. NHTSA defines a “high-level alcohol crash” as one where an active participant has a BAC of 0.10 or higher. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* calls for all 50 States to lower legal blood alcohol concentration tolerance levels to 0.04 percent for motor vehicle drivers age 21 and older and .00 percent for those younger than 21. Other ways to lower the BAC levels of drivers include:

- Using planning and zoning ordinances to control the type and number of outlets selling alcohol, as well as the particular hours of the day alcoholic beverages are available for sale;
- Raising the priority of law officers’ programs designed to deter drinking and driving, including sobriety checkpoints;
- Implementing programs to promote responsible alcoholic beverage service in both commercial and social settings;
- Organizing comprehensive, community-based awareness programs, including mass media promotion, to counter the adverse consequences of alcohol use in high risk situations, including driving;
- Making the enforcement of underage sales and drinking laws a priority.

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Center for Substance Abuse Prevention. The Center for Substance Abuse Prevention (CSAP) was created by the Anti-Drug Abuse Act of 1986. Originally called the Office for Substance Abuse Prevention the name was changed to CSAP as part of a 1992 reorganization of the Federal Alcohol, Drug Abuse, and Mental Health Administration. CSAP is the focus of the U.S. Department of Health and Human Services' efforts to prevent alcohol, tobacco, and other drug problems nationwide. CSAP provides information and assistance to national, regional, State, and community prevention efforts.

CSAP advocates no use of any illegal drugs and no illegal or high risk use of alcohol, tobacco, or other legal drugs. And since research has shown that virtually no one initiates tobacco, alcohol, or other drug (except cocaine and prescription drugs) use after age 25, CSAP focuses its efforts on influencing the attitudes and practices of young people regarding alcohol, tobacco, and other drugs.

While CSAP supports prevention programs for all segments of the population, the Anti-Drug Abuse Act defined CSAP's primary target group as "high-risk youth" whose environment or lifestyle puts them at high risk of developing problems with alcohol, tobacco, and other drugs. These youths include one or more of the following categories:

- Economically disadvantaged youth;
- School drop outs or those at risk of dropping out;
- Pregnant teenagers or teenage parents;
- Children of alcoholics;
- Delinquents who may be involved with youth gangs;
- Runaways or homeless youth;
- Abused or neglected youth;
- Latchkey youth; or
- Users of gateway drugs, including alcohol, marijuana, or tobacco.

Also among CSAP's target audiences are pregnant women and postpartum mothers who are using alcohol, tobacco, or other drugs, as well as their children.

While it is impossible to predict who will develop alcohol, tobacco, or other drug problems, CSAP's help in identifying these special risk factors has allowed prevention practitioners to better focus their efforts.

The Anti-Drug Abuse Act in 1988 significantly expanded the scope and function of CSAP and its mandate was broadened to a more community-wide focus. CSAP's two major programs are the "Community Partnership" and "High-Risk Youth" grant programs. It also administers

other prevention programs and activities, including the National Clearinghouse for Alcohol and Drug Information (NCADI), the CSAP Training System, the National Perinatal Addiction Resource Center, and the National Volunteer Training Center.

CSAP's approach to its responsibilities is based on the premises that: (1) the earlier prevention is started in a person's life, the more likely it will succeed; (2) prevention programs should be knowledge-based, incorporating state-of-the-art findings and practices drawn from scientific research and expertise; (3) prevention programs should be comprehensive, e.g., include components of education, health care, social service, religion, and law enforcement, as well as family involvement; (4) programs should include process as well as outcome evaluations to ensure that knowledge derived from prevention programs is validated and disseminated to communities; and (5) successful programs are most likely initiated and conducted by communities themselves.

Through CSAP's National Clearinghouse for Alcohol and Drug Information, RADAR Network Centers, and training conferences sponsored throughout the country, CSAP maintains open lines of communication with the public. Those with comments or suggestions are encouraged to write:

Office of the Director
Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Rockwall II Building
Rockville, MD 20857

For more information on CSAP, the RADAR Network, or any topic related to prevention, including information about current grant funding opportunities, contact:

CSAP's National Clearinghouse for Alcohol and Drug Information
P.O. Box 2345
Rockville, MD 20847-2345
1-800-729-6686
TDD 1-800-487-4889

Children of Alcoholics. Children of alcoholics (COAs) face special problems as a result of living in a home disrupted by alcohol problems. An estimated 6.6 million children under the age of 18 live in households with at least one alcoholic parent.

What are characteristics of the typical COA? A mistake often made by prevention practitioners is to cluster all COAs into rigid behavioral categories. However, each child's personality and reaction to parental alcohol dependence is unique. One child may fail classes, while another may escape stress by studying for perfect grades. Some rebel, while others are overly compliant. In addition, factors at home such as marital conflict or severity of parental drinking, can influence acting-out behaviors.

While certain tendencies are found more commonly in COAs, they can also describe children raised in other types of dysfunctional families. Young COAs may exhibit more symptoms of depression and anxiety, including crying, bedwetting, social isolation, fear of school, or nightmares. Older youths may isolate themselves for long periods of time, claiming they have "no one to talk to." COAs may have difficulty relating to teachers, other students, and school. Teenagers may be perfectionists, hoarders, excessively self-conscious, or prone to phobias. They often believe that they are failures, even if they do well academically.

Most COAs do not develop serious problems coping with life. One study found that 59 percent of COAs had not developed serious coping problems by age 18. Researchers have found that maintaining consistency around important family activities such as vacations, mealtimes, or holidays, are protective factors for some families with parental alcoholism. Children can also have some protection if the active alcoholic is confronted and seeks help, if family rituals or traditions are maintained, if consistent significant others are around, and if there is moderate to high religious observance.

Although there is a genetic component to vulnerability for alcohol dependence, COA issues are not related primarily to alcohol use and problems, but instead to social and psychological dysfunction that may result from growing up in an alcoholic home. Most COAs do not develop alcohol problems. In research samples, two-thirds of alcoholics did not have one or more alcoholic parents. Still, COAs are two to four times more likely to develop alcohol problems than others. That they are at higher than average risk of developing problems merits the attention of prevention practitioners.

It is not always possible to identify COAs and provide intervention services. If the parent is receiving treatment, preventive services, such as mentoring, can be provided for the child. Prevention activities can include information on alcoholism and resources so that older COAs can seek out assistance through schools or community agencies.

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Cocaine. Cocaine is one of the most powerfully addictive of the drugs of abuse—and it is a drug that can kill. No individual can predict whether he or she will become addicted or whether the next dose of cocaine will prove fatal. Cocaine can be snorted through the nose, smoked, or injected. Injecting cocaine—or injecting any drug—carries the added risk of infection with HIV, the virus that causes AIDS, if the user shares a needle with a person already infected with the virus.

Cocaine is a very strong stimulant to the central nervous system, including the brain. This drug produces an accelerated heart rate while at the same time constricting the blood vessels, which are trying to handle the additional flow of blood. Pupils dilate and temperature and blood pressure rise. These physical changes may be accompanied by seizures, cardiac arrest, respiratory arrest, or stroke.

Nasal problems, including congestion and a runny nose, occur with the use of cocaine; with prolonged use the mucous membrane of the nose may disintegrate. Heavy cocaine use can sufficiently damage the nasal septum to cause it to collapse.

Research has shown that cocaine acts directly on the “pleasure centers” in the brain. These pleasure centers are brain structures that, when stimulated, produce an intense desire to experience the pleasure effects again and again. This causes changes in brain activity and, by allowing a brain chemical called dopamine to remain active longer than normal, triggers an intense craving for more of the drug.

Users often report feelings of restlessness, irritability, and anxiety, and cocaine can trigger paranoia. Users also report being depressed when they are not using the drug and often resume use to alleviate further depression. In addition, cocaine users frequently find that they need more and more cocaine more often to generate the same level of stimulation. Therefore, any use can lead to addiction.

“Freebase” is a form of cocaine that is smoked. Freebase is produced by a chemical process whereby street cocaine (cocaine hydrochloride) is converted to a pure base by removing the hydrochloride salt and some of the cutting agents. The end product is not water soluble; the only way to get it into the system is to smoke it.

Freebasing is extremely dangerous. The cocaine reaches the brain within seconds, resulting in a sudden and intense high. However, the euphoria quickly disappears, leaving the user with an enormous craving to freebase again and again. The user usually increases the dose and the frequency to satisfy this craving, resulting in addiction and physical debilitation.

Crack is the street name given to one form of freebase cocaine that comes in the form of small lumps or shavings. The term "crack" refers to the crackling sound made when the mixture is smoked (heated). Smoking crack is very dangerous since it produces the same debilitating effects as freebasing cocaine. Crack has become a major problem in many American cities because it is inexpensive—selling for between \$5 and \$10 for one or two doses—and easily transportable—sold in small vials, folding paper, or tinfoil.

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College and University Students. Alcohol has long been the drug of choice among U.S. college students, who drink at higher rates than their non-college counterparts. College students spend approximately \$4.2 billion annually to purchase 430 million gallons of alcoholic beverages, including over 4 billion cans of beer. Students have particularly high rates of heavy drinking compared to the general population.

Student drinking is the number one health problem on college and university campuses throughout the Nation. Alcohol consumption contributes to a range of problems among college students, including academic problems, trauma, date rape, and vandalism. College students are at a higher risk for alcohol-related problems because they have high rates of heavy consumption, tend to drink more recklessly than others, are vulnerable to other risks that are exacerbated by alcohol (e.g., suicide, automobile crashes, and falls), and are heavily targeted by the advertising and promotions of the alcoholic beverage industry.

Surveys on alcohol and other drug use by college students have found:

- 41 percent report binge drinking in the last 2 weeks;
- Nearly 4 percent drink daily;
- Approximately one-third have used marijuana in the past year; and
- 5.6 percent have used cocaine in the past year, 0.6 percent used crack, 4.3 percent used LSD, and a combined total of 3.3 percent used heroin and/or opiates.

Alcohol is associated with missed classes and poor performance on tests and projects. The number of alcoholic drinks per week is clearly related to lower GPAs. In the Core Alcohol and Drug Survey of 56,000 college students, students who reported D and F grade point averages consumed an average of 11 alcoholic drinks per week, while those who earned mostly As consumed only 3 drinks per week.

While many institutions have been working for many years to prevent alcohol and other drug problems, colleges and universities received additional impetus to review existing campus alcohol and other drug policies with the implementation of the U.S. Drug-Free Schools and Communities Act Amendments of 1989 (Public Law 101-226). It requires that institutions of higher learning receiving Federal funds attest that they have adopted and implemented a drug prevention program for students and employees.

The following describes what some campuses are doing to reduce alcohol and other drug problems:

Enforcement. According to one study, to discourage the use of false identification to purchase alcohol 58 percent of colleges impose a fine or probation, 9 percent suspend students, and 22 percent report the offenses to law enforcement authorities and/or the motor vehicles bureau.

Availability. Virtually every college campus in America regulates alcohol availability in some manner. Beer is banned on 25 percent of the campuses, and 33 percent do not allow distilled spirits on campus. Other restrictions on availability include requirements that parties with alcoholic beverages be registered with campus officials and meet minimum standards of responsible hosting. The Core Survey found that 67 percent of non-bingeing students would prefer an alcohol-free campus environment and almost 94 percent would prefer a drug-free environment

Pricing. Because the availability of cheap alcohol contributes to high risk drinking, some campuses have restricted or banned campus advertisements that promote reduced priced drinks at happy hours for students. Others have imposed strict controls on keg parties that promote “all you can drink” for a fixed price.

Peer Counseling. Many colleges train peer counselors to educate groups and individuals about the dangers of alcohol use. For example, fraternity and sorority members reach out to fellow fraternity and sorority members, an especially important group. Studies have shown that fraternity members drink more frequently and at higher levels than other college students.

Advertising/Sponsorship. Some colleges limit or ban alcohol advertising in student newspapers and sponsorship of student events by alcoholic beverage companies. The Fraternity Insurance Purchasing Group (FIPG), the largest insurer to fraternities nationwide, adopted a risk management policy that, among other provisions, includes a prohibition of cosponsorship of fraternity events with an alcohol distributor or tavern.

Alcohol-Free Residence Halls. The California State University at Chico banned alcohol in residences. An emerging trend is for colleges to establish residence halls where students sign pledges that they will not use alcohol, tobacco, or other drugs.

The Department of Education sponsors The Network of Colleges and Universities Committed to the Elimination of Drug and Alcohol Abuse, which includes over 1,300 institutions of higher education. Also, DoEd supports grants to many schools through the Fund for the Improvement of Postsecondary Education (FIPSE).

There is a small, but significant downward trend in the prevalence of alcohol and other drug use among college students. This trend mirrors a similar pattern of a small, national reduction in consumption.

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Community Action Groups. In the last decade nonprofit groups known as community action groups or community-based coalitions have formed to bring about large-scale prevention efforts in their communities. Typically, community action groups are initiated by civic-minded private citizens. For instance, in Jackson, Mississippi, a father started STIK (Stop the Teen Intoxication Kick) when his 14-year-old son's best friend was caught with alcohol. In Kensington, Maryland, an automobile dealership owner started DADD (automobile Dealers Against Drunk Driving) after reading that crashes were the leading killer of young people.

While community action groups typically start with one person, their success depends on enlisting others with skills and resources to achieve their objectives. For example, the Washington, DC, Regional Alcohol Program (WRAP) began with a few citizens in 1982 and has succeeded through infusions of new people, ideas, and resources over time.

The founding members of WRAP began the community action group with a news conference announcing their formation. The publicity drew volunteers and donations to support activities. With no paid staff, WRAP decided to undertake four multimedia campaigns each year along with a youth seminar to encourage local teens to form safety clubs in their schools. They held news conferences to launch each campaign, and placed prevention messages on donated posters, t-shirts, pins, pens, milk cartons, and gas pumps, and in tuxedo pockets, flower boxes, package liquor bags, restaurant windows, office elevators, paycheck envelopes, and grocery bags.

Several years after the formation of WRAP there were substantial changes in the Washington, DC, area. Alcohol-related deaths dropped by more than 17 percent. In 4 of the 6 years of WRAP's Operation Prom Graduation, which involved 175 high schools, there were no alcohol-related fatalities among high school seniors. Although it is not possible to prove that these changes were a direct result of WRAP's activities, the outcome is encouraging.

Perhaps one of the most well-known community action groups is Mothers Against Drunk Driving (MADD). Started in 1980 by Candy Lightner after her daughter was killed by an alcohol-impaired driver with prior convictions for driving under the influence, MADD had some 357 chapters nationwide by 1985. MADD's purpose is to both secure justice for those who have been harmed by alcohol-impaired driving and to prevent future alcohol-impaired driving.

Forming a Community Action Group

The key to starting a successful community action group is to enlist the active support of opinionmakers, advocates, and volunteers.

- *Opinionmakers* are those in leadership positions who are considered to be influential in the community, such as the mayor and other political leaders; presidents of community organizations, service clubs, and business or professional organizations; newspaper editors and

publishers, and local TV and radio personalities; and professional athletes. Because of their status in the community, opinionmakers are often effective spokespersons for prevention issues. They can also provide access to those who shape the laws and opinions of the community and be a valuable asset in fund-raising.

- *Advocates* are those who, in the course of their professional lives, can have an impact on the audiences for community action initiatives. They may include doctors, dentists, nurses, other medical personnel, teachers, coaches, school administrators, treatment professionals, social workers, psychologists, nutritionists, police, clergy, retailers, media representatives, and opinionmakers. They help build credibility for a community action group by their active support and participation in educating the community.
- *Volunteers* can be either individuals or members of a group, such as auxiliaries, parents' groups, senior citizens' groups, or local volunteer bureaus. The role of volunteers is central to the success of a community action group. Volunteers can perform all the tasks needed for a successful community action group, including program administration, grant writing, activities development, community organizing, and public education.

Community action groups are emerging across the Nation. Their numbers are predicted to increase during the next decade as community members seek to develop local responses to alcohol, tobacco, and other drug problems. A major national study by Join Together, funded by The Robert Wood Johnson Foundation, confirmed that nearly every State, most major cities, and many rural areas have broad-based community coalitions that combine public and private resources. More than half the 1,650 community coalition respondents said that at least 20 percent of their funding was covered by both the Federal and State governments. For more information about the survey, contact Join Together, 441 Stuart Street, Sixth Floor, Boston, MA 02116; (617)437-1500.

With the right mix of opinionmakers, advocates, and volunteers, funding in the form of cash and in-kind services to support local efforts is often not difficult to obtain. Initiatives such as CSAP's Community Partnerships grant program and The Robert Wood Johnson Foundation's Fighting Back grants provide support to community action coalitions that can act as models for other communities.

The Fighting Back program helps community groups—business, education, health care, social services and law enforcement—join together to prevent and treat alcohol and other drug problems. One of the 13 sites selected for the Foundation's \$18 million program is Little Rock, Arkansas. With the Foundation's seed grant of 25 percent of the first-year premium cost, the city launched an innovative program to provide each student in kindergarten through 12th grade with insurance for early intervention and treatment services. For more information, contact The Robert Wood Johnson Foundation, P.O. Box 2316, Princeton, NJ 08543-2316; (609)452-8701.

A resource for community action groups is the National Association of Neighborhoods (NAN). This organization is a national association of neighborhood groups such as tenant associations, resident advisory committees, and others that organize around many of the issues that interact with alcohol, tobacco, and other problems. NAN offers assistance with entrepreneurial development programs in public housing, community policing programs, peer advisory programs, and other community action activities. For additional information write to: National Association of Neighborhoods, 1651 Fuller Street, NW, Washington, DC 20009; (202)332-7766.

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Community Partnerships. Through the early 1980s, preventing alcohol, tobacco, and other drug problems was viewed as primarily an educational effort, with a focus on efforts to change individual behavior, usually through classroom lessons. But both experience and evaluation studies have shown that a "systems approach" can be significantly more effective.

A systems approach views the community and the environment as interconnected parts, each affected by the others and needing to work together. Because the individual parts have the potential either for supporting or undermining prevention efforts of other parts, the goal of any community serious about prevention is to make the parts work together. Cooperation and support through a systems approach move communities closer to creating environments for youths that consistently discourage involvement with alcohol, tobacco, and other drugs.

Through its Community Partnerships grant initiative, CSAP is supporting over 250 projects nationwide that emphasize building relationships and coalitions among individuals and groups. These individuals and groups are referred to as collaborating agencies and include health services, faith community organizations, law enforcement and judicial organizations, treatment services, groups and individuals involved in education, civic and volunteer organizations, members of the business community, government agencies, human services/social service groups, and recreation organizations. The 5-year demonstration grants support the development of long-term primary prevention efforts in communities as large as a county or as small as a neighborhood within a city.

Communities that have Partnership grants determine their activities based on the existing level of community involvement with alcohol, tobacco, and other drug prevention. For some it means building a new coalition from the ground up. Others may work to strengthen existing coalitions, or help several separate endeavors come together in a single, coordinated effort.

CSAP provides training opportunities for Partnership grantees, including a 4- to 5-day "Training Institute." Partnerships are encouraged to send a team to the Institute to learn about technical aspects of prevention, concepts of community organizing, and multiculturalism. Teams also create mission statements for their Partnerships and plan for the work ahead.

To supplement the team training, CSAP offers courses around the country, at no charge to the Partnerships, on topics such as "Community Organizing Through Community Change" and "Treatment Providers as Prevention Partners: The Missing Link."

Community Partnership grants reflect CSAP's commitment to prevention planning and systems development through community cooperation. The intent of Community Partnership grants is to bring together the major sectors of the community including the business community, as well as community residents, to develop collaborative community prevention strategies. Community development strategies are at the heart of these prevention efforts. Increased community ownership of prevention issues will

lead to more effective efforts to both address the root causes of community risk factors and increase community resiliency.

In 1992, CSAP's Division of Community Prevention and Training accepted a new responsibility to provide national leadership in efforts that initiate, promote, and support the development of worksite prevention policies that focus on alcohol, tobacco, and other drug abuse, as well as HIV/AIDS issues in the workplace. Current efforts include assisting the Community Partnership Program grantees to increase their business commitment and participation in workplace prevention activities. In addition the CSAP Drug-Free Workplace Helpline provides guidance to private sector business, industry, and labor on effective workplace substance abuse prevention policies and programs.

Another organization working for community collaboration is the Community Anti-Drug Coalitions of America (CADCA), which fosters networking and regional cooperation among coalitions, helping them share information and expertise. Created at the recommendation of the President's Drug Advisory Council and funded in part by a grant from The Robert Wood Johnson Foundation, CADCA provides training, technical assistance, and resource referral to assist community coalition efforts.

REFERENCES

- Prevention Plus II: Tools for Creating and Sustaining a Drug-Free Community* (1991) BK159
- Getting It Together: Promoting Drug-Free Communities. A Resource for Developing Effective Youth Coalitions* (1992) PHD579
- The Future by Design. A Community Framework: Preventing Alcohol and Other Drug Problems Through a Systems Approach* (1991) BK189
- How Neighbors Are Helping Neighbors: A Profile of NAN Members.* Washington, DC: National Association of Neighborhoods (1992) BKD101
- Join Together National Survey.* Boston, MA: Join Together: A National Resource for Communities Fighting Substance Abuse (1993)
- CSAPs Drug-Free Workplace Helpline 1-800-843-4971

Continuum of Service. Prevention is part of an interrelated continuum of service that also includes intervention and treatment, often referred to as secondary and tertiary prevention. Under a public health approach, prevention is differentiated from intervention, treatment, and rehabilitation in that it is aimed at general population groups with various levels of risk for alcohol, tobacco, and other drug related problems. Using public health terms, these activities are referred to as primary prevention. In contrast, secondary prevention is concerned with the early detection and reduction of alcohol, tobacco, and other drug problems once they have begun, and tertiary prevention is concerned with preventing further deterioration and reducing problems associated with the specific disorder or disease.

From a public health perspective, prevention services include all those activities directed at population groups that are intended to protect against the occurrence of problems. Primary prevention often relies on an alcohol, tobacco, and other drugs-related problem-oriented model to assist in the development of policies, regulations, and behavioral norms to alter drinking and other drug use practices. In contrast, secondary and tertiary prevention includes activities intended to rehabilitate individuals who suffer, are likely to suffer, or are seen by others to be suffering from problems related to alcohol, tobacco, and other drug use. Those services are often referred to as crisis intervention, early case-finding, targeted education, peer group intervention, detoxification and inebriate reception services, and both residential and non-residential supportive recovery and/or treatment services.

To understand the relationship between prevention, intervention, and treatment, imagine a series of safety nets. Each is designed to protect people from the adverse consequences of alcohol, tobacco, or other drug problems, depending on how far the problems have developed. This progressive array of nets represents prevention, intervention, and treatment.

The first net represents prevention. The dictionary defines prevention as decisive counteraction to stop something from happening. We also know that prevention provides individuals with information and resources to raise their awareness of both risky and healthy behaviors, and helps shape environments to promote health and protect people from harm.

Intervention is the next safety net. For youth, intervention targets those who have already begun to use alcohol, tobacco, or other drugs, with the goal of preventing further use. Intervention may also be directed at youths who have not yet begun to use, but who are at greater risk for use because of environmental or other factors. For adults, intervention may target those who have begun to experience problems with alcohol or who are using other drugs. The goal is to stop use or, in some cases, reduce alcohol consumption to low risk levels, thus preventing the development of further alcohol-related problems.

The third and final safety net is treatment for those who are experiencing alcohol, tobacco, or other drug problems. The goal of treatment services is

the prevention of further physical, social, and psychological damage through total abstinence.

Prevention, intervention, and treatment represent a continuum of services. For example, an education program to educate students about alcohol, tobacco, and other drugs (a prevention activity) may increase the number of people who recognize for the first time that they have a family member with a problem. They may decide to discuss the problem with them (an intervention activity). Or some may recognize their own problems with alcohol or other drugs and enter a recovery program (a treatment activity). The relationship between prevention, intervention, and treatment also acknowledges that treatment may fail if attention is not given to the prevention of relapse through changes in the individual and environmental factors that lead to alcohol, tobacco, and other drug problems.

According to the Department of Education (DoEd), "There is little evidence to challenge the basic premise that prevention is the most humane and cost-effective response to alcohol and other drug use and related problems." On the continuum of services, prevention—stopping problems before they start—is preferable to treating casualties.

REFERENCES

- A Promising Future: Alcohol and Other Drug Problem Prevention Services Improvement. CSAP Monograph 10 (1992) BK191*
- Toward a Drug-Free Generation: A Nation's Responsibility. U.S. Department of Education and Office of National Drug Control Policy (1990) BKD55*

Cultural Competence. Culture plays a complex role in the development of alcohol, tobacco, and other drug use. Culture is the shared values, norms, traditions, customs, arts, history, folklore, music, and institutions of a group of people. Cultural competence means understanding and appreciating the cultural differences and similarities within, among, and between groups.

For prevention practitioners to become culturally competent requires both the willingness and the ability to draw on community-based values, traditions, and customs. Working with knowledgeable persons of and from the community in the development of focused interventions and communications promotes cultural competence in prevention efforts.

An emerging trend for community-based prevention efforts is to increase program ownership by community organizations and institutions. Programs with staff who are members of the same ethnic and racial groups as the community they are serving is one way to promote culturally sensitive prevention activities. Encouraging cultural pride through activities and events provides community members with a means to learn more about themselves and their heritage, and to draw from cultural strengths to reduce problems related to alcohol, tobacco, and other drug use.

Cultural competence helps prevention practitioners avoid stereotypes and biases that can undermine prevention efforts. It promotes a focus on the positive characteristics of a particular group, and instills prevention activities with an appreciation of cultural differences.

Language and terminology are important issues. The United States is a diverse, multicultural society. Terms like "minority" are considered by some to be inappropriate, if not offensive. Cultural competence means understanding the importance of the use of language and terminology to different groups and striving for terminology consensus so that communication can be more effective.

Ethnic and racial groups are frequently referred to in broad categories, such as African Americans, Hispanic/Latinos, American Indians and Native Alaskans, or Asian and Pacific Islander Americans. Cultural competence helps prevention practitioners understand that such categories can mask substantial differences among subgroups. It is important for prevention efforts to distinguish those differences and reflect the culture diversity of community members.

Prevention practitioners who become culturally competent are more likely to be effective in their efforts. In a multicultural society each community offers a rich and diverse ethnic heritage that, if fully explored and understood, will play an important role in the development of alcohol, tobacco, and other drug problem prevention programs that focus on strengthening cultural resiliency and protective factors.

REFERENCE

Cultural Competence for Evaluators (1992) BKD79

Dietary Guidelines for Alcohol. Based on the Dietary Guidelines for Americans set by the Department of Health and Human Services and the Department of Agriculture, CSAP has developed the following guidelines on alcohol consumption.

Adults who are considering drinking alcoholic beverages should have only low-risk drinking as a goal, if they choose to drink. The lowest risk is not to drink, which should always be acceptable. Adult women who elect to drink should limit their consumption to no more than one drink per day. Men who elect to drink should limit their consumption to no more than two drinks per day. Underage youth should not drink.

These circumstances place drinkers at high risk for health, social, and/or legal consequences:

- If underage;
- If pregnant, nursing, or trying to conceive;
- If driving or engaging in other activities that require attention, judgment or skill;
- If taking medication that interacts with alcohol;
- If recovering from alcohol or other drug dependence;
- If drinking to intoxication;
- If drinking cannot be done in moderation.

REFERENCE

Dietary Guidelines for Americans, Department of Health and Human Services and Department of Agriculture (1990)

Drug Testing in the Workplace. Seventy percent of current illicit drug users are employed. This means that more than 10 million employees use illicit drugs, making the workplace an important environment in which to intervene with drug users and to help prevent employees from starting to use illegal drugs.

One method of identifying employees who use illicit drugs is through drug testing in the workplace. Although this remains controversial and is often opposed unless it is for cause, companies that use drug testing send a strong message that they support non-drug using employees to remain drug-free and encourage occasional drug users to stop.

A recent Gallup poll of employees found that 97 percent agreed that workplace drug testing is appropriate under certain circumstances and 85 percent believed that urine testing may deter illicit drug use. Thus, testing for the right reasons has the support of most employees and there is some evidence that drug testing helps prevent illicit drug use.

“Workplace safety” is the reason most commonly given by employers for drug testing. Testing has been suggested for prospective and current employees in industry; for the armed forces; for parolees and bail seekers; for transportation industry employees; and for professional athletes, who are often role models for young people.

Workplace drug testing is used in five different ways:

- Pre-employment or applicant testing (used most commonly);
- Post-accident or for-cause testing;
- Scheduled testing (used during routine physicals, for example);
- Random testing (used for job categories involving public safety or security); and
- Treatment follow-up testing (used to monitor an employee’s success in remaining drug free).

Urine screening can be a useful tool in identifying employees with potential drug problems. The majority of the largest employers in the United States have adopted urine screening and approximately 20 percent of employed Americans have a drug testing policy in their workplaces. Although urine screening is considered relatively reliable, any drug testing program should retest positive samples, with a scientifically valid confirmation test. Care must also be taken in handling urine samples to avoid mislabeling and ensure that test results are valid and reliable.

Legal counsel is advisable for those planning a drug testing program. Drug testing related lawsuits filed against employers include invasion of privacy, wrongful discharge, defamation, intentional infliction of emotional distress, employer negligence, assault and battery, false imprisonment, and discrimination against minorities or people with disabilities.

Despite controversy, statistics show that comprehensive prevention programs in the workplace with education and training programs for workers and supervisors, high laboratory standards for drug testing, and the availability of treatment and rehabilitation services for workers with problems reduce drug use and improve health, safety, and productivity. Implementing a drug-testing program can be an important part of a comprehensive approach to establishing a drug-free workplace.

REFERENCES

- Comprehensive Procedures for Drug Testing in the Workplace* (1991) PHD548
An Employer's Guide to Dealing with Substance Abuse (1990) PHD543
CSAP's Drug-Free Workplace Helpline: 1-800-843-4971
Drug Abuse in the Workplace: Employer's Guide for Prevention. Washington, DC: U.S. Chamber of Commerce (1988)

Editorial Guidelines. Quality prevention materials play an important role in reducing alcohol, tobacco, and other drug problems. CSAP developed "Suggested Terminology for Developing Materials About Alcohol and Other Drug Problems" to aid developers of materials and messages. The following is an excerpt from that guide.

Using the expression "alcohol and other drugs, including tobacco" emphasizes the too often overlooked fact that alcohol and tobacco are drugs.

The term "use" should be employed when making statements about people who should not drink alcohol: youth, pregnant women, recovering alcoholics, or operators of motor vehicles or other machinery. In all other cases, the terms "misuse" and "abuse" are more appropriate. Concerning illicit drugs, the term "use" is more descriptive and may connote less of a judgment than the term "abuse," which may imply that "use" is permissible but "abuse" is not.

Because drug use should not be considered recreational, avoid the term "recreational use of drugs," which trivializes drug taking behavior. "Drug use" is also preferred to the term "responsible use," because there is some risk (health, social, and/or legal) associated with all use.

Avoid using derogatory terms such as "drunks," "potheads," or "dope fiends." These expressions show a lack of respect for individuals with problems and may alienate the very people toward whom prevention efforts are aimed.

Because a person's driving can be impaired before the person reaches a drunken state, the term "alcohol-impaired driving" or "drinking and driving" is preferable to "drunk driving."

For more information, write to Director, Division of Communications Programs, Center for Substance Abuse Prevention, 5600 Fishers Lane, Rockwall II, Rockville, MD 20857.

REFERENCE

CSAP Editorial Style Guidelines: Suggested Terminology for Developing Materials About Alcohol and Other Drug Problems (1992)

Employee Assistance Programs. Employees with alcohol and other drug problems cost U.S. employers billions of dollars in lost productivity and increased health care expenses. According to one study, in comparison with other employees, a typical employee experiencing problems with alcohol or other drug use:

- Was late three times more often;
- Requested time off 2.2 times more often;
- Had 2.5 times as many absences of 8 days or more;
- Used three times the normal level of sick benefits;
- Was five times more likely to file a worker's compensation claim; and
- Was involved in accidents 3.6 times more often.

Attention to employee alcohol and other drug problems first emerged in the 1970s and expanded rapidly into the 1980s with the spread of Employee Assistance Programs (EAPs) to help employees overcome problems that may interfere with their work, including alcohol and other drug use, other health issues, as well as personal, marital, family, legal, and financial problems. Usually based on a written policy statement, EAPs provide a means for supervisors, managers, and union shop stewards to access appropriate expertise and consultation and help with employees experiencing such problems. EAPs also provide for employee self-referral, and in many instances, provide services to dependents of employees.

An important characteristic of EAPs is an emphasis upon constructive rather than punitive treatment of employees experiencing alcohol or other drug problems. The underlying assumption of EAPs is that help for employees will reduce turnover and enable them to resume effective work performance.

Employees who work for larger companies are more likely to have access to the services of an EAP. One study found that 52 percent of workplaces with 750 or more employees have EAPs, compared with 15 percent for workplaces with 50 to 99 employees. In total, over 80 percent of large U.S. firms have EAPs and over 31 percent of all American workers are employed by companies with EAPs. CSAP is developing a program through its Workplace Community Prevention Branch to assist smaller workplaces gain access to EAPs for their employees.

An EAP is a worksite-based program designed to assist in the identification and resolution of productivity problems associated with employees whose performance and/or conduct is adversely affected by personal concerns including, but not limited to: health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal concerns.

Core activities of the typical EAP include: (1) expert consultation and training to appropriate persons in the identification and resolution of job-performance issues related to the aforementioned employee personal

concerns; (2) confidential, appropriate and timely problem-assessment; (3) referrals for appropriate diagnosis, treatment and assistance; (4) the formation of linkages between workplace and community resources that provide such services; and (5) follow-up services for employees who use those services.

The services that EAPs offer include crisis intervention, assessment and referral, short-term problem resolution, monitoring and follow-up, supervisor/union representative training and consultation, organizational consultation, program promotion, and education.

There are several types of EAP models.

- The internal program is company-staffed by an employee who accepts both supervisor- and self-referrals, conducts initial assessments, and refers employees to community resources for counseling or treatment.
- The external program is for companies that want to contract with outside agencies to provide most services of the EAP, including assessment.
- The labor union model is staffed by qualified union representatives and serves union members. The primary service offered is referral.
- The professional association program includes the possibility of license withdrawal as an inducement for members to obtain assistance.
- The consortia model is often used by small or medium-sized companies. It enables these businesses to combine resources and efforts for the provision of EAP services. By joining several work populations into a single group, small businesses are able to contract with an EAP provider to deliver services at a quantity discount.

There are also two major organizations that foster the development of EAPs and strive to improve the quality of EAP services. The Employee Assistance Professionals Association (EAPA) and the Employee Assistance Society of North America (EASNA) are national organizations whose professional membership includes EAP directors and counselors, behavioral health specialists, organizational development specialists, workplace researchers, and labor leaders.

EAPs are often part of a larger employer effort to promote the health and fitness of employees. Programs to promote wellness are becoming more and more common in the workplace. Wellness programs are generally described as efforts to maintain good health by changing destructive habits and having people take greater responsibility for the state of their health. Employers have come to realize the importance of educating people about the health effects of alcohol and other drug use, stress, poor eating habits, and other controllable aspects of their lifestyles. The idea behind corporate wellness programs is to prevent problems from occurring and not having to treat problems after they have occurred.

REFERENCES

- How Drug Abuse Takes Profit Out of Business. How Drug Treatment Helps Put it Back* (1991) PHD574
- An Employers Guide to Dealing with Substance Abuse* (1990) PHD543
- NIDA Capsule: Resources to Address Drugs in the Workplace* (1990) CAP38
- What Works: Workplaces Without Drugs* (1991) PHD517
- Workers at Risk: Drugs and Alcohol on the Job* (1990) PHD521
- CSAP's Drug-Free Workplace Helpline: 1-800-843-4971
- Standards for Employee Assistance Programs: Part 2.* (1992) The Employee Assistance Professionals Association
- EAPs: Value and Impact.* (1991) The Employee Assistance Professionals Association

Environmental Approaches to Prevention.

Environmental approaches to prevention are an important part of comprehensive responses to alcohol, tobacco, and other drug problems. Contemporary strategies to prevent alcohol, tobacco, and other drug problems are often based on a public health model. This model, derived from the communicable disease model, stresses that problems arise through a reciprocal relationship among the agent, the host, and the environment.

In the case of alcohol, tobacco, and other drug problems, the agent is the alcohol, tobacco, or drug, the host is the individual drinker or user, and the environment is the social and physical context of drinking or use. Of particular importance to prevention are the environmental influences on drinking and other drug use.

Environmental approaches for reducing alcohol problems reflect a relatively recent change in how we as a society view alcohol, tobacco, and other drug problems. Until recently the principal prevention strategies focused on education and early treatment. In this view education was intended to inform society about the disease of addiction and to teach people about the early warning signs so that they could initiate treatment as soon as possible. Now efforts focus on "high risk" populations and attempt to correct a suspect process or flaw in individuals, such as low self esteem or lack of social skills. The belief is that the success of education and treatment efforts in solving each individual's problems will solve society's alcohol, tobacco, and other drug problems as well.

Prevention researchers generally agree that the most effective approach to reducing alcohol, tobacco, and other drug problems is through a public health systems approach that acknowledges the complexity of the interactions contributing to the development of problems.

This view is disputed by the alcoholic beverage industry, which seeks to attribute societal alcohol problems solely to the misuse of its product by a deviant subpopulation of problem drinkers or alcoholics. Current environmental messages regarding alcohol consumption are strongly influenced by the marketing and promotional activities of the alcohol industry, and are little driven by health and welfare concerns. Those messages are:

- *Drinking is encouraged in virtually all situations.*

Example: Advertising slogans like "Put a little weekend in your week."

- *Potential risks of drinking are downplayed.*

Examples: Alcoholic beverage sponsorship of racing cars or speedboats, proliferation of gas station mini-marts selling chilled single cans of beer to go.

- *Abstinence is actively discouraged.*

Examples: The brandy advertisements that declare “I assume you drink”; frequent drinking on TV programs unrelated to plot development.

- *Heavier consumption is actively encouraged.*

Example: Happy hour two-drinks-for-the-price-of-one promotions, or packaging to encourage larger purchases like 12 packs of beer or liters of wine coolers.

- *Individual-focused prevention efforts deny the role of environmental factors.*

Example: Alcoholic beverage industry-sponsored prevention campaigns tell individuals to “Know when to say when” or “Friends don’t let friends drive drunk.”

It is within this environmental context that drinking patterns of the general population are shaped and problems develop. Contemporary prevention activities seek to change that environment through a range of activities, from raising community awareness to enacting regulatory measures to control how, where, and when alcoholic beverages are marketed, served, and sold. Often these prevention measures are opposed by the alcoholic beverage industry, which usually opposes regulatory measures and uses its considerable influence to lobby policymakers who have the power to enact environmental change measures.

The key to environmental approaches is the acknowledgment that alcohol, tobacco, and other drug problems are the result of complex interactions over time. As problems vary from place to place and time to time, no set of specific strategies will be appropriate for every instance. Thus, effective prevention must be integrated into community life and operate in complex social and economic environments to assist community members with the difficult decisions necessary to effect social change.

The development of problems is not individually based but rather the result of behaviors influenced by factors occurring in a variety of environments that contribute to an array of community level problems. For example, within this model efforts to reduce problems associated with drinking and driving might include an intervention directed at high risk contexts and environments such as server training for reducing the likelihood of drinking to intoxication by patrons in licensed establishments. For other drugs, environmental interventions might seek to change the economic lure of the illicit drug trade by developing jobs for inner city youth, or providing opportunities for success in alternative activities, such as sports or cultural endeavors.

In a public health approach to prevention emphasis is placed on system-level changes in those social, cultural, and economic environments most likely to yield desired reductions in alcohol, tobacco, and other drug problems.

REFERENCES

- Youth and Drugs: Society's Mixed Messages. CSAP Prevention Monograph 6* (1990) BK172
- Working with Youth in High Risk Environments: Experiences in Prevention. CSAP Prevention Monograph 12* (1992) BKD80
- The Future by Design. A Community Framework: Preventing Alcohol and Other Drug Problems Through a Systems Design* (1991) BK198
- Booze Merchants: The Inebriating of America.* Washington, DC: Center for Science in the Public Interest (1983)

Evaluation. Often evaluation is the most neglected tool of prevention practitioners. Some believe that they cannot afford to spend time analyzing past efforts when there are so many new activities to organize. Others are convinced that evaluation is a highly technical activity that requires the services of experts at a cost that many organizations simply cannot afford.

Evaluation is valuable when it helps prevention practitioners look back at what they have done and finish this sentence: "Next time, to do it better, we will" Prevention practitioners who self-evaluate are simply asking themselves "What did we do? What effect did our efforts have?" Each time they learn the answers to those questions they have a better understanding of whether or not their efforts were successful. Then they can make more informed decisions to improve future efforts. By learning about the strengths and weaknesses of their activities, prevention practitioners can improve their efforts over time.

Lack of time, money, and technical expertise does not have to preclude prevention practitioners from obtaining valuable feedback on their activities and possible impact on target audiences and problems.

First, time spent on evaluation is not wasted because it allows groups to use their money and other resources more efficiently in the future. Second, evaluation does not have to be expensive or complicated to be useful. There are evaluation efforts that involve little or no cost. Finally, evaluations do not have to be completed by professionals or be totally comprehensive. Program practitioners can evaluate as few or as many aspects of their efforts as they choose.

Simple evaluation techniques require little time and effort; others require thorough, formal, professional-type evaluations. Often, with a little creativity, an evaluation can be done for no, or very little cost. For example, contact with a college or university may result in identifying a professor or graduate student interested in conducting a program evaluation as a special project. Sources for potential evaluators are departments of sociology, educational psychology, psychology, social work, biostatistics, educational communication, public health, health sciences, or marketing. Another possibility is using professional evaluators who are volunteers associated with the program, such as people with backgrounds in psychology, statistics, or research design. These volunteers may be willing to conduct a formal evaluation as part of their contribution to the program.

Types of Evaluation

There are three major types of evaluations: outcome, process, and impact. Following is a description of each with some guidelines on when they could or should be used. In weighing the options, the evaluator will recognize that a combination of approaches may best serve the evaluation objectives.

Outcome Evaluation. Did the stated objectives for change in the target population occur? Applying the measures of change to the target population before and after the intervention is the principal method of

conducting outcome evaluations. The change measured may be drug and alcohol use, attitudes toward use, or attitudes or other attributes of the target population. Questionnaires that measure change are a means of conducting an outcome evaluation.

Process Evaluation. When using this type of evaluation, ask this question, "Were the procedures which comprised the intervention activity performed in the manner intended in the evaluation design?" For example, if 10 classroom sessions of 1 hour each at 1 month intervals were the intervention activity, did they occur as intended and was the material to be delivered done so in the manner intended. Monitoring of the intervention activity is one mechanism for conducting the process evaluation.

Impact Evaluation. When using this type of evaluation, ask this question, "What effect did the intervention activity have on components of the system in which the activity was targeted?" Both negative and positive outcomes that are corollary to the intervention objective may occur. Structured collection of such impact information can provide important information to the planning of subsequent intervention activities. Interviews with officials of the system can yield some impact information, while more indepth study of particular aspects of the system--such as dropout rates or attendance in a school system--may be instructive.

Evaluation Tools

Most prevention practitioners initiate self-evaluation on a small scale, selecting from a variety of simple evaluation tools that reflect their level of resources and skills.

Evaluation tools available to prevention practitioners are debriefing, observations, in-depth personal interviews, target audience groups, questionnaires, and comparisons.

Debriefing. Debriefing for evaluation purposes may involve a meeting of the important players in a prevention activity to ask questions and listen to anecdotes. In this setting, problem areas are often revealed, as well as project aspects that were so successful they should be duplicated or expanded in the future.

When conducting debriefings, prevention practitioners should:

- Praise jobs well done;
- Emphasize the contributions of each individual and his/her value to the team; and
- Make sure players do not feel they are being harshly judged. If they think they are being criticized, they are not likely to share honest opinions and perceptions.

Observation. Using this technique, the evaluator attends an activity as if he or she were a typical member of the target audience. For example, a prevention practitioner on a college campus might unobtrusively attend a campus seminar on “Families with Alcohol and Other Drug Problems” to note how many students are there, if they are traditional or nontraditional students, the level of audience interest, kinds of questions asked, and possible need for a follow-up seminar or an on-campus support group.

In-Depth Personal Interviews. Personal Interviews are used when detailed information is needed about what a target audience thinks and feels about an activity or approach. Most in-depth personal interviews last between 30 minutes and 1 hour.

The first step in conducting in-depth personal interviews is to develop a list of non-leading, revealing questions. An interviewer meets with a member of the target audience privately, asks the questions, and writes down the responses. To be representative of the target audience a minimum of four in-depth personal interviews should be conducted before the results are used for future planning purposes.

In-depth personal interviews might be used to assist a prevention practitioner in evaluating a video on impaired driving. An impartial interviewer might work with the prevention practitioner to develop a series of open-ended questions, including: What did you think about the video? What were your thoughts about the content? The presentation? Was any of the information new to you? What was most interesting? Least interesting? How did you feel about the discussion? Will what you heard affect you in the future? How? Would you like to see the video changed in any way?

Target Audience Groups. Target audience groups, when led by moderators in more structured situations, are known as focus groups and can cost up to \$3,000 per group when professionally conducted. But prevention practitioners can hold simple target audience groups, modeled after more formal focus groups, often at no cost and with little effort.

Target audience groups are similar to debriefings, except members of the target audience are called together rather than those who organized the prevention activity or program. A moderator asks open-ended questions and listens more than speaks. Target audience groups offer a dimension that in-depth personal interviews do not because they allow participants to discuss the topic freely and spontaneously, with only a minimal amount of guidance from the moderator.

A target audience group should include 10 to 12 people, and last no longer than 90 minutes. Moderators do not take notes during the session because that can make the group uncomfortable. Usually the session is tape recorded and transcribed to develop a proceedings report.

Group members should not know each other. However, this cannot be avoided in some situations. Only first names are used, and participants are assured that their anonymity will be protected in the final report.

The following is an example of the use of target audience groups for evaluation. In developing a series of brochures for parents of teenagers, one prevention organization obtained from the local PTA a list of 20 parents reflecting a diverse mixture of ethnic groups and income levels. Two separate target audience groups were organized. The moderator presented rough paste-ups of the brochures and led the parents through a group discussion of the strengths and weaknesses of the art work, design, format, and content. The groups' suggestions led to numerous changes that enhanced the appeal of the final brochures to the target audience.

Questionnaires. Questionnaires are probably the most commonly used evaluation tool. Questionnaires allow program administrators to gather and tabulate information from a large number of respondents. Questions can be included to provide a descriptive profile of the target audience. Questionnaires also encourage honesty by assuring respondents' anonymity.

Typical questionnaires include both closed- and open-ended questions. Closed-ended questions limit the answers that may be given by offering multiple choices, yes/no answers, or scales of agreement/disagreement to statements. Closed-ended questions are easier to tabulate and quantify. But one or more open-ended questions can be helpful, as these lead to information about comprehension and overall impressions.

Comparisons. Comparisons are often used in television commercials such as "children who brushed with this toothpaste had 20 percent fewer cavities than those who brushed with other brands."

Using statistics can be deceptive sometimes because it is often difficult to attribute changes in problems to prevention efforts, other factors, or a combination of both. In addition, progress for prevention efforts may be no change in problems if problems would have increased without a prevention effort.

The following example uses statistics to compare changes over time. The number of high school students who drink dropped 9 to 13 percent each year that the Positive Peer Program was operating. Those who report using other drugs dropped 15 percent.

One advantage of statistics is that results can be reported in a standardized manner and be used to promote a program. Promotion of an organization's success can encourage volunteers to join and stimulate corporate sponsors to make donations for future efforts.

Conclusions

Regardless of the combination of evaluation tools used—debriefings, observations, in-depth personal interviews, target audience groups, questionnaires, or comparisons—the true value of evaluation lies in increasing effectiveness. Capitalizing on successes and avoiding past mistakes make evaluation activities worthwhile for most organizations.

REFERENCES

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- Research, Action, and the Community: Experiences in the Prevention of Alcohol and Other Drug Problems. CSAP Prevention Monograph 4* (1990) BK167
- Cultural Competence for Evaluators. CSAP Cultural Competence Series 1* (1992) BKD79
- Prevention Plus III: Assessing Alcohol and Other Drug Prevention Programs at the School and Community Level* (1991) BK188
- Experiences with Community Action Projects: New Research in the Prevention of Alcohol and Other Drug Problems. CSAP Prevention Monograph 14* (1993) BKD87
- Drug Abuse Prevention Intervention Research: Methodological Issues. NIDA Research Monograph 107* (1991) M107

Federal Agencies. The complex system that makes up the Federal Government includes many agencies that deal with primary, secondary, or tertiary prevention with varying levels of involvement. They are: ACTION, Administration for Children and Families, Administration for Native Americans, Bureau of Indian Affairs, Centers for Disease Control and Prevention, Center for Substance Abuse Prevention, Center for Substance Abuse Treatment, U.S. Coast Guard, Department of Defense, Department of Education, Department of Housing and Urban Development, Department of Justice, Department of Labor, Department of Veterans Affairs, Drug Enforcement Administration, Federal Bureau of Investigation, Indian Health Service, National Highway Traffic Safety Administration, National Institute on Alcohol Abuse and Alcoholism, National Institute on Drug Abuse, Office of Juvenile Justice and Delinquency Prevention, Office of National Drug Control Policy, Office of Personnel Management, and Substance Abuse and Mental Health Services Administration.

This section includes addresses for each agency and a brief description of their involvement with alcohol, tobacco, and other drug problem prevention activities.

ACTION

1160 Vermont Avenue, NW
Washington, DC 20525
(202)634-9757

ACTION is a national agency that promotes volunteerism, with a mission that is carried out by more than 476,000 local volunteers in communities around the country. Its programs help meet basic human needs and support the self-help efforts of low-income individuals and communities. The agency consists of a Washington, DC, headquarters, nine regional offices, and individual State offices.

The volunteer programs ACTION operates related to alcohol and other drug problem prevention include the Drug Alliance Office, Older American Volunteer Programs, Volunteers in Service to America (VISTA), and Student Community Service Program.

Administration for Children and Families (HHS)

330 C Street, SW
Washington, DC 20201
(202)245-0051

The Administration for Children and Families promotes services and programs to support the well-being of children and families.

Administration for Native Americans
 200 Independence Avenue, SW
 Room 344-F, Hubert Humphrey Building
 Washington, DC 20201
 (202)245-7776

The Administration for Native Americans (ANA) promotes the economic and social self-sufficiency of American Indians, Native Alaskans, and Native Hawaiians through the provision of grants, training, and technical assistance. Its efforts include prevention efforts targeting this population.

Bureau of Indian Affairs
 Department of the Interior
 18th and C Streets, NW
 Mailstop 2620
 Washington, DC 20240
 (202)343-1191

The Bureau of Indian Affairs (BIA), under the Assistant Secretary for Indian Affairs, establishes the priorities, policies, planning, and evaluation requirements for prevention activities that target BIA employees, tribal governing bodies, and reservation/village constituents in 32 States. Acting through the Deputy to the Assistant Secretary for Indian Affairs, the Office serves as the senior advisor to the Assistant Secretary on aspects of prevention initiatives.

Centers for Disease Control and Prevention
 1600 Clifton Road
 Atlanta, GA 30333
 (404)639-3824

The Centers for Disease Control and Prevention (CDC) is the Federal agency charged with protecting the public health of the Nation. Through its Planned Approach to Community Health (PATCH) program, the CDC works with State and local health departments and community members to organize local intervention programs. The CDC provides materials and technical assistance and communities invest time and resources to make the programs work. PATCH programs have focused on such areas as smoking cessation and alcohol problems.

Center for Substance Abuse Prevention
 SAMHSA/CSAP
 5600 Fishers Lane
 Rockwall II Building
 Rockville, MD 20857
 (301)443-0373

Established in 1986 to lead the Federal Government's efforts toward the prevention and intervention of alcohol, tobacco, and other drug problems, the Center for Substance Abuse Prevention (CSAP) administers two major prevention programs, the "Community Partnership" and "High-Risk Youth" grant programs, as well as other prevention programs and activities, including the National Clearinghouse for Alcohol and Drug Information.

Center for Substance Abuse Treatment
 SAMHSA/CSAT
 5600 Fishers Lane
 Rockwall II, Tenth Floor
 Rockville, MD 20857
 (301)443-2467

The Center for Substance Abuse Treatment (CSAT) funds residential and non-residential treatment programs serving pregnant and postpartum women and their children, grants to States for additional alcohol and other drug services, counselor training programs, alcohol and other drug recovery services in State and local criminal justice systems, demonstration programs of national significance, as well as the State block grant program.

U.S. Coast Guard
 Public Affairs Staff
 2100 Second Street, SW
 Washington, DC 20593
 (202)267-1587

The United States Coast Guard (USCG) is a branch of the Armed Forces and an agency of the Department of Transportation. Stopping drug smuggling into the United States is a high priority, and the Coast Guard is expanding its educational programs in this area. It also develops and directs a national boating safety program, encouraging recreational boaters to avoid alcohol and other drugs.

Department of Defense
 OSD Health Affairs
 PA and QA
 3D366, Pentagon
 Washington, DC 20301-1200
 (202)695-7116

Through the Department of Defense (DoD), prevention and education efforts are implemented worldwide through education, training, public service announcements on Armed Forces radio and television, posters, and pamphlets.

Department of Education
 Drug Abuse Prevention Oversight Staff
 Office of the Secretary
 400 Maryland Avenue, SW
 Washington, DC 20202-0120
 (202)401-3030

The Department of Education (DoEd) administers the largest block of Federal funds devoted to the prevention of alcohol and other drug problems. Its Division of Drug-Free Schools and Communities has two branches. The first, the State and Local Programs Branch, provides formula funding through State education agencies and governors' offices. It also oversees DoEd's five Regional Centers for Drug-Free Schools and Communities that supply technical assistance to schools and communities.

The second branch of the Division of Drug-Free Schools and Communities is the Discretionary Programs Branch, which oversees grant competitions for State and local education agencies in five discretionary grant programs, including programs for school personnel training and school-based community programs in alcohol and other drug prevention education.

DoEd's Fund for the Improvement of Postsecondary Education (FIPSE) addresses the problem of alcohol and other drugs on campuses by providing funds for prevention initiatives.

DoEd has also developed a wide range of prevention materials that are available through the Center for Substance Abuse Prevention's National Clearinghouse for Alcohol and Drug Information.

Department of Housing and Urban Development
451 Seventh Street, SW
Washington, DC 20410
1-800-245-2691

The Department of Housing and Urban Development (HUD) operates the HUD Drug Information and Strategy Clearinghouse that deals specifically with alcohol and other drug problems in public housing projects.

Department of Justice
Office of Justice Programs
633 Indiana Avenue, NW
Washington, DC 20531
(202)307-5933

The Department of Justice (DoJ) forms partnerships with State and local governments to help policymakers, practitioners, and citizens understand what crime costs in terms of public safety and the social and economic health of communities. It awards formula grants to States and to specific crime prevention programs.

DoJ operates the National Criminal Justice Reference Service (NCJRS), which provides comprehensive information on criminal justice issues on the national and international level, and the Drugs & Crime Data Center & Clearinghouse (DCDCC), which specializes in the collection of data on drugs and crime.

Among the primary prevention programs sponsored by the DoJ is the National Citizens Crime Prevention Campaign, which is operated through the National Crime Prevention Council. Through this effort, numerous print and video materials on prevention have been developed.

Department of Labor
Washington, DC 20210
Substance Abuse Information Database
1-800-775-SAID

Through the Substance Abuse Information Database (SAID), the U.S. Department of Labor provides employers, and those organizations that work with employers, with information that will assist them in developing

workplace substance abuse programs. It describes prevention materials and where they can be obtained. It provides information related to Federal and State legislation, as well as information on studies and surveys on how drugs and alcohol affect the workplace.

Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420
(202)535-7970

Formerly the Veterans Administration, the Department of Veterans Affairs (VA) became a Cabinet-level department in March 1984. The primary mission of the VA with regard to alcohol and other drug problems is to provide treatment services to eligible veterans with dependence disorders. Because of the VA's treatment focus, prevention activities concentrate on secondary and tertiary prevention. Most treatment programs, through academic affiliations and community outreach activities, are also involved in primary prevention.

Drug Enforcement Administration
Washington, DC 20537
(202)307-7936

The Drug Enforcement Administration (DEA) is responsible for the enforcement of Federal drug laws and regulations. It has conducted prevention programs in conjunction with numerous national organizations, including the National High School Athletic Coaches Association, the Ladies Professional Golf Association, the National Youth Sports Coaches Association, and the Boy Scouts of America. DEA also develops and distributes a variety of publications and videos on prevention.

Federal Bureau of Investigation
Drug Demand Reduction Program
10th Street and Pennsylvania Avenue, NW
Washington, DC 20535
(202)324-5611

The Federal Bureau of Investigation (FBI) is the lead Federal investigative agency within the Department of Justice. Among other prevention activities, the FBI disseminates drug demand reduction materials to appropriate organizations, makes public presentations on drug awareness, and works closely with demand reduction specialists of other organizations. The FBI headquarters and field offices work with citizens from across the country who are actively involved in drug prevention and education efforts.

Indian Health Service

Alcoholism and Substance Abuse Program Branch
 Room 6A-53
 5600 Fishers Lane
 Rockville, MD 20857
 (301)443-4297

The Alcoholism and Substance Abuse Program Branch of the Indian Health Service (IHS) has initiated a number of programs that provide prevention services to members of American Indian and Native Alaskan communities.

National Highway Traffic Safety Administration

Traffic Safety Programs (NTS-21)
 400 Seventh Street, SW
 Washington, DC 20590
 (202)366-2721

A major focus of the National Highway Traffic Safety Administration (NHTSA) is the prevention of impaired driving. NHTSA provides resources to State and community law enforcement agencies, as well as impaired driving programs, and has developed a range of prevention publications.

National Institute on Alcohol Abuse and Alcoholism/NIH

16C-03 Parklawn Building
 5600 Fishers Lane
 Rockville, MD 20857
 (301)443-1677

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is a research organization that focuses on alcohol-related problems. In addition to providing leadership to the research community, NIAAA supports scientific information dissemination and public education activities to inform the public of the risks and consequences associated with alcohol abuse and alcohol dependence.

National Institute on Drug Abuse/NIH

5600 Fishers Lane
 10A-54 Parklawn Building
 Rockville, MD 20857
 1-800-662-HELP

The National Institute on Drug Abuse (NIDA) is the lead Federal agency for drug abuse research. NIDA disseminates its research findings to the public through various means—such as the press, community education programs, NIDA's Drug Abuse Hotline, and publications distributed by CSAP's National Clearinghouse for Alcohol and Drug Information.

Office of Juvenile Justice and Delinquency Prevention

635 Indiana Avenue, NW
 Washington, DC 20531
 (202)307-5914

Part of the Department of Justice, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) provides national leadership and resources

to help States and local jurisdictions improve their juvenile justice systems. Program priorities are prevention and control of illegal drug use by juveniles, prevention and control of serious juvenile crime, and missing and exploited children.

Office of National Drug Control Policy
Executive Office of the President
Washington, DC 20500
(202)673-2520

The Office of National Drug Control Policy (ONDCP) is headed by the Director of National Drug Control Policy, a Presidential appointee, commonly referred to as the "drug czar." ONDCP is charged with explaining the nature of the illicit drug problem in America and presenting a policy that includes roles for the Federal, State, and local governments, and the private sector. It also produces documents addressing national alcohol- and drug-related priorities in areas such as criminal justice, drug treatment, education, community action, the workplace, international, interdiction, and research. Copies of these publications are available from CSAP's National Clearinghouse for Alcohol and Drug Information.

Office of Personnel Management
1900 E Street, NW
Washington, DC 20415
(202)632-5558

The Office of Personnel Management (OPM) is an independent agency in the executive branch that oversees and regulates matters pertaining to civil service personnel management. OPM's primary function related to alcohol and other drug problem prevention focuses on workplace employee assistance programs. OPM provides regulatory and policy guidance in the Code of Federal Regulations; the Federal Personnel Manual; and through publications, conferences, and seminars regarding EAPs for Federal civilian employees. Additionally, OPM is required to report annually to Congress on programs to prevent problems for Federal civilian employees.

Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857
(301)443-6315

The Substance Abuse and Mental Health Services Administration (SAMHSA) administers alcohol and other drug and mental health service-related programs. SAMHSA's focus is on prevention, intervention, and treatment services and its primary role is to coordinate the delivery of these services to health professionals and the general public. SAMHSA is made up of three agencies: the Center for Substance Abuse Prevention (CSAP), the Center for Substance Abuse Treatment (CSAT), and the Center for Mental Health Services (CMHS).

Gay, Lesbian, & Bisexual Youth/ Adults.

Research has found that gay, lesbian, and bisexual Americans are at increased risk for alcohol and other drug problems. Although this audience comprises more than 10 percent of people at risk for problems, alcohol and other drug programs generally do not address their prevention needs.

Because of the historical stigmatization of gay, lesbian, and bisexual people, few prevention programs are inclusive of gay and lesbian culture. If community norms are intolerant of sexual diversity, separate prevention strategies may be necessary. A systematic approach to alcohol and other drug problem prevention requires an understanding of the risk factors for this audience. They include:

- History of family alcohol and other drug problems
- Physical, sexual, or psychological abuse and victimization
- School drop-out
- Attempted suicide
- Low self esteem/efficacy
- Inadequate social services
- Homelessness
- Pro-use norms in the community
- Lack of role models

It is not enough to assume that gay, lesbian, and bisexual youth and adults are included in other high-risk category prevention and treatment programs. Their vulnerability to alcohol and other drug use is unique and exacerbated by feelings of rejection by their environment and self. They often feel rejected because of their sexual orientation, over which they have no control. Prevention efforts that are not affirming of gay, lesbian, and bisexual persons are not only nonproductive, they may increase problems.

Prevention strategies recommended for the gay, lesbian, and bisexual communities include:

- Providing training on issues for this community to police, social service staff, foster care families, teachers, principals, religious leaders, health care providers, and others.
- Increasing community understanding and acceptance of homosexuality.
- Supporting families of gay, lesbian, and bisexual youth and involving them in prevention efforts.
- Educating community members about the link between alcohol and other drug use with AIDS, sexually transmitted disease, date rape, and family violence.

- Providing peer support and recovery groups in the gay, lesbian, and bisexual community.
- Sponsoring alcohol, tobacco, and other drug-free events.
- Providing structured workshops on "coming out."
- Involving established gay, lesbian, and bisexual organizations in prevention efforts.

Like other communities, the gay, lesbian, and bisexual community is typified by its own history, customs, values, and social and behavioral norms. It has clearly identified festivals, holidays, rituals, symbols, heroes, language, art, music, songs, and literature. Effective prevention efforts must both reflect and mobilize the culture of the gay, lesbian, and bisexual community.

REFERENCES

Cultural Competence for Evaluators (1992) BKD79

Proceedings, The Research Symposium on Alcohol and Other Drug Problem Prevention Among Lesbians and Gay Men. California Department of Alcohol and Drug Programs (1991)

Heroin. Heroin is an illegal opiate drug. Its addictive properties are manifested by the need for persistent, repeated use of the drug (craving) and by the fact that attempts to stop using the drug lead to significant and painful physical withdrawal symptoms. Use of heroin causes physical and psychological problems such as shallow breathing, nausea, panic, insomnia, and a need for increasingly higher doses of the drug to get the same effect.

Heroin exerts its primary addictive effect by activating many regions of the brain; the brain regions affected are responsible for producing both the pleasurable sensation of reward and physical dependence. Together, these actions account for the user's loss of control and the drug's habit-forming action.

Heroin is a drug that is primarily taken by injection (a shot) with a needle in the vein. Injectable drugs can have grave consequences. Uncertain dosage levels (due to differences in purity), the use of unsterile equipment, contamination of heroin with cutting agents, or the use of heroin in combination with such other drugs as alcohol or cocaine can cause serious health problems such as serum hepatitis, skin abscesses, inflammation of the veins, and cardiac disease (subacute bacterial endocarditis). Of great importance, however, is that the user never knows whether the next dose will be unusually potent, leading to overdose, coma, and possible death.

Needle sharing by injected drug users is fast becoming one of the leading causes of new AIDS cases. The AIDS virus is carried in contaminated blood left in the needle, syringe, or other drug-related implements and is injected into the new user when he or she uses this equipment to inject heroin or other drugs. There is no cure for AIDS and no proven vaccine to prevent it.

Heroin use during pregnancy is associated with stillbirths and miscarriages. Babies born addicted to heroin must undergo withdrawal after birth and these babies show a number of developmental problems.

The signs and symptoms of heroin use include euphoria, drowsiness, respiratory depression (which can progress until breathing stops), constricted pupils, and nausea. Withdrawal symptoms include watery eyes, runny nose, yawning, loss of appetite, tremors, panic, chills, sweating, nausea, muscle cramps, and insomnia. Elevation in blood pressure, pulse, respiratory rate, and temperature occurs as withdrawal progresses.

Symptoms of a heroin overdose include shallow breathing, pinpoint pupils, clammy skin, convulsions, and coma.

REFERENCE

What You Can Do About Drug Use in America (1991) PHD587

Hispanic/Latino. The Hispanic/Latino community is often considered by prevention practitioners a hard-to-reach population, implying that their language or cultural differences represent a barrier to prevention information and outreach. However, for many of the Nation's largest consumer products manufacturers and retailers, the Hispanic/Latino community is highly accessible, and represents strong growth markets.

According to CSAP's *Prevention Monograph 5: Communicating About Alcohol and Other Drugs: Strategies for Reaching Populations at Risk*, the challenge to those in the prevention field is to move away from regarding Hispanic/Latinos as hard-to-reach and toward an approach that builds on research and demonstration findings regarding successful communication strategies aimed at this large and growing population group. While knowledge about effective ways to prevent alcohol, tobacco, and other drug problems among Hispanic/Latinos is not entirely definitive, there is a growing body of promising approaches. In addition, communications networks serving primarily Hispanic/Latino communities are valuable, but currently under-used resources for prevention practitioners.

When developing prevention initiatives directed at the Hispanic/Latino community, it is important to recognize that it represents a population group that:

- Consists of diverse subgroups, including Mexican Americans, Puerto Ricans, Central Americans, South Americans, and Cubans;
- Has experienced dramatic population growth in the United States;
- Includes a large proportion of young people;
- Includes a high proportion of female-headed households, compared to the general population;
- Includes proportionately fewer married couples than the general population;
- Places high importance on the family;
- May experience conflict between generations related to differences in acculturation; and
- Is at a higher risk for teen pregnancy and juvenile incarceration than youth in the general population.

Over the past 20 years, the Hispanic/Latino community has emerged as one of the fastest growing segments of the United States population. The high growth rate is projected to continue. Data from the Census Bureau suggest that the Hispanic/Latino population will grow at a rate of approximately five times the non-Hispanic/Latino white population in upcoming years. Consequently, prevention practitioners must understand the knowledge, attitudes, and practices of Hispanic/Latinos regarding alcohol, tobacco, and other drug use and problems.

While information is limited, studies on alcohol, tobacco, and other drug use in the Hispanic/Latino populations indicate that:

- Hispanic/Latinos in general may have lower rates than non-Hispanic/Latino whites of lifetime use of alcohol, PCP, hallucinogens, and stimulants;
- Hispanic/Latino youths ages 12 to 17 may have higher rates of cocaine use than their non-Hispanic/Latino counterparts;
- Puerto Rican and Cuban youths may have the highest rates of cocaine use among Hispanic/Latinos;
- Mexican Americans ages 12 to 17 may have higher rates of marijuana use than non-Hispanic/Latino whites;
- Hispanic/Latino children have extensive exposure at an early age to alcohol and other drug use;
- Younger Hispanic/Latino women in general use alcohol much less than Hispanic/Latino men;
- Younger Hispanic/Latino women may use alcohol more than the women in their parents' generation, perhaps as a result of acculturation;
- Hispanic/Latinos in general may believe that drinking is an acceptable way to celebrate and have fun; and
- May believe that drinking is a primary source of inappropriate behavior.

Prevention programs or strategies should neither begin nor end with information campaigns. Activities should focus on building the desire, resources, and mechanisms to promote healthy behaviors and environments. While appropriate national roles exist for developing leadership, research and data, and prototypes of programs, a community-based commitment to prevention is necessary for the national prevention component to fulfill its potential.

For prevention practitioners, working with Hispanic/Latino communities requires an appreciation of the dynamics of change—diversification of subgroups within geographic areas; evolving values and norms; shifts in family structure and religious affiliation; and transitions in attitudes toward and use of alcohol, tobacco, and other drugs. An appreciation of change should be combined with an understanding of deeply rooted beliefs and values that lie at the core of the Hispanic/Latino experience. Together, they can bring relevance and power to prevention efforts targeting Hispanic/Latino communities.

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- Alcohol and Other Drug Use Among Hispanic Youth. CSAP Technical Report 4 (1990) BK179*
- Caetano, R. "Alcohol Use among Hispanic Groups in the United States," *American Journal of Drug and Alcohol Abuse* 14:293-308, 1988
- The Fact Is...Reaching Hispanic/Latino Audiences Requires Cultural Sensitivity (1990) MS406*
- Communicating About Alcohol and Other Drugs: Strategies for Reaching Populations at Risk. CSAP Prevention Monograph 5 (1992) BK170*
- "The Nation's Health: Special Populations" In *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. Washington, DC: Department of Health and Human Services (1991)
- "¿Pura Vida? ¡Puras Mentiras! The Alcoholic Beverage Industry Targeting of Latinos" The Marin Institute for the Prevention of Alcohol and Other Drug Problems (1992)

Healthy People 2000. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* was adopted by the U.S. Department of Health and Human Services in 1990. *Healthy People 2000* is a statement of national opportunities. It is the product of a national effort, involving 22 expert working groups, almost 300 national organizations, all the State health departments, and the Institute of Medicine of the National Academy of Sciences.

Healthy People 2000 lists three goals: (1) increase the span of healthy life for Americans, (2) reduce health disparities among Americans, and (3) achieve access to preventive services for all Americans. It also includes 19 objectives specific to alcohol and other drugs:

1. *Reduce deaths caused by alcohol-related motor vehicle crashes* to no more than 8.5 per 100,000 people.

2. *Reduce cirrhosis deaths* to no more than 6 per 100,000 people.

3. *Reduce drug-related deaths* to no more than 3 per 100,000 people.

4. *Reduce drug abuse-related hospital emergency department visits* by at least 20 percent.

5. *Increase by at least 1 year the average age of first use of cigarettes, alcohol, and marijuana* by adolescents ages 12 through 17.

6. *Reduce the proportion of young people who have used alcohol, marijuana, and cocaine in the past month, as follows:*

<i>Substance/Age:</i>	<i>Baseline 1988(%)</i>	<i>Target 2000(%)</i>
Alcohol/12-17	25.2	12.6
Alcohol/18-20	57.9	29
Marijuana/12-17	6.4	3.2
Marijuana/18-25	15.5	7.8
Cocaine/12-17	1.1	0.6
Cocaine/18-25	4.5	2.3

7. *Reduce the proportion of high school seniors and college students engaging in recent occasions of heavy drinking of alcoholic beverages* to no more than 28 percent of high school seniors and 32 percent of college students.

8. *Reduce alcohol consumption by people age 14 and older* to an annual average of no more than 2 gallons of ethanol per person.

9. Increase the proportion of high school seniors who perceive social disapproval associated with the heavy use of alcohol, regular use of marijuana, and experimentation with cocaine, as follows:

Behavior	Baseline 1989(%)	Target 2000(%)
Heavy Use of Alcohol	44	70
Regular Use of Marijuana	71.1	85
Cocaine Experimentation	88.9	95

10. Increase the proportion of high school seniors who associate risk of physical or psychological harm with the heavy use of alcohol, regular use of marijuana, and experimentation with cocaine, as follows:

Behavior	Baseline 1989(%)	Target 2000(%)
Heavy Use of Alcohol	44	70
Regular Use of Marijuana	77.5	90
Cocaine Experimentation	54.9	80

11. Reduce to no more than 3 percent the proportion of male high school seniors who use anabolic steroids.

12. Establish and monitor in all 50 States comprehensive plans to ensure access to alcohol and drug treatment programs for traditionally underserved people.

13. Provide to children in all school districts and private schools primary and secondary school education programs on alcohol and other drugs, preferably as a part of a quality school health education.

14. Extend adoption of alcohol and drug policies for the work environment to at least 60 percent of worksites with 50 or more employees.

15. Extend to 50 States administrative driver's license suspension/revocation laws or programs of equal effectiveness for people determined to have been driving under the influence of intoxicants.

16. Increase to 50 States the number of States that have enacted and enforce policies, beyond those in 1989, to reduce access to alcoholic beverages by minors.

17. Increase to at least 20 the number of States that have enacted statutes to restrict promotion of alcoholic beverages that is focused primarily on young audiences.

18. Extend to 50 States legal blood alcohol concentration tolerance levels of 0.04 percent for motor vehicle drivers age 21 and older and .00 percent for those younger than 21.

19. Increase to at least 75 percent the proportion of primary care providers who screen for alcohol and other drug use problems and provide counseling and referral as needed.

Each objective includes background information on baseline information for the objective, as well as recommended strategies for achieving the year 2000 objectives. For further information regarding the alcohol and other drug objectives in *Healthy People 2000* call NCADI at 1-800-729-6686.

Historical Overview of Prevention. Alcoholic beverages have been a part of the Nation's past since the landing of the Pilgrims. According to *Alcohol and Public Policy: Beyond the Shadow of Prohibition*, a publication commissioned by NIAAA and prepared by the National Academy of Sciences, the colonists brought with them from Europe a high regard for alcoholic beverages, which were considered an important part of their diet. Drinking was pervasive because alcohol was regarded primarily as a healthy substance with preventive and curative powers, not as an intoxicant. Alcohol was also believed to be conducive to social as well as personal health. It played an essential role in rituals of conviviality and collective activity, such as barn raisings. While drunkenness was condemned and punished, it was viewed only as an abuse of a God-given gift.

The first temperance movement began in the early 1800s in response to dramatic increases in production and consumption of alcoholic beverages, which also coincided with rapid demographic changes. Agitation against ardent spirits and the public disorder they spawned gradually increased during the 1820s. In addition, inspired by the writings of Benjamin Rush, the concept that alcohol was addicting, and that this addiction was capable of corrupting the mind and the body, took hold. The American Society of Temperance, created in 1826 by clergymen, spread the anti-drinking gospel. By 1835, out of a total population of 13 million citizens, 1.5 million had taken the pledge to refrain from distilled spirits. The first wave of the temperance movement (1825 to 1855) resulted in dramatic reductions in the consumption of distilled spirits, although beer drinking increased sharply after 1850.

The second wave of the temperance movement occurred in the late 1800s with the emergence of the Women's Christian Temperance Movement, which, unlike the first wave, embraced the concept of prohibition. It was marked both by the recruitment of women into the movement and the mobilization of crusades to close down saloons. The movement set out to remove the destructive substance, and the industries that promoted its use, from the country. The movement held that while some drinkers may escape problems of alcohol use, even moderate drinkers flirted with danger.

The culmination of this second wave was the passage of the 18th Amendment and the Volstead Act, which took effect in 1920. While Prohibition was successful in reducing per capita consumption and some problems related to drinking, its social turmoil resulted in its repeal in 1933.

Since the repeal of Prohibition, the dominant view of alcohol problems has been that alcoholism is the principal problem. With its focus on treatment, the rise of the alcoholism movement depoliticized alcohol problems as the object of attention, as the alcoholic was considered a deviant from the predominant styles of life of either abstinence or "normal" drinking. The alcoholism movement is based on the belief that chronic or addictive drinking is limited to a few, highly susceptible individuals suffering from the disease of alcoholism. The disease concept of alcoholism focuses on individual vulnerability, be it genetic, biochemical, psychological, or

social/cultural in nature. Under this view if the collective problems of each alcoholic are solved, it follows that society's alcohol problem will be solved.

Nevertheless, the pre-Prohibition view of alcohol as a special commodity has persisted in American society and is an accepted legacy of alcohol control policies. Following Repeal, all States restricted the sale of alcoholic beverages in one way or another in order to prevent or reduce certain alcohol problems. In general, however, alcohol control policies disappeared from the public agenda as both the alcoholism movement and the alcoholic beverage industry embraced the view, "the fault is in the man and not in the bottle."

This view of alcoholism problems has also been the dominant force in contemporary alcohol problem prevention. Until recently the principal prevention strategies focused on education and early treatment. Within this view education is intended to inform society about the disease and to teach people about the early warning signs so that they can initiate treatment as soon as possible. Efforts focus on "high risk" populations and attempt to correct a suspect process or flaw in the individual, such as low self esteem or lack of social skills. The belief is that the success of education and treatment efforts in solving each alcoholic's problem will solve society's alcohol problem as well.

Contemporary alcohol problem prevention began in the 1970s as new information on the nature, magnitude, and incidence of alcohol problems raised public awareness that alcohol can be problematic when used by any drinker, depending upon the situation. There was a renewed emphasis on the diverse consequences of alcohol use—particularly trauma associated with drinking driving, fires, and violence, as well as long term health consequences.

The history of nonmedical drug use, and the development of policies in response to drug use, also extends back to the early settlement of the country. Like alcohol, the classification of certain drugs as legal, or illegal, has changed over time. These changes sometimes had racial and class overtones. According to Mosher and Yanagisako, for example, Prohibition was in part a response to the drinking practices of European immigrants, who became the new lower class. Cocaine and opium were legal during the 19th century, and were favored drugs among the middle and upper classes. Cocaine became illegal after it became associated with African Americans following Reconstruction. Opium was first restricted in California in 1875 when it became associated with Chinese immigrant workers. Marijuana was legal until the 1930s when it became associated with Mexicans. LSD, legal in the 1950s, became illegal in 1967 when it became associated with the counterculture.

By the end of the 19th century concern had grown over the indiscriminate use of these drugs, especially the addicting patent medicines. Cocaine, opium, and morphine were common ingredients in various potions sold over the counter. Until 1903, cocaine was an ingredient of Coca-Cola®. Heroin, which was isolated in 1868, was hailed as a nonaddicting treatment for morphine addiction and alcoholism. States began to enact control and

prescription laws and, in 1906, Congress passed the Pure Food and Drug Act. It was designed to control opiate addiction by requiring labels on the amount of drugs contained in products, including opium, morphine, and heroin. It also required accurate labeling of products containing alcohol, marijuana, and cocaine.

The Harrison Act (1914) imposed a system of taxes on opium and coca products with registration and record-keeping requirements in an effort to control their sale or distribution. However, it did not prohibit the legal supply of certain drugs, especially opiates.

Current drug laws are rooted in the 1970 Controlled Substances Act. Under this measure drugs are classified according to their medical use, their potential for abuse, and their likelihood of producing dependence. The Act contains provisions for adding drugs to the schedule, and rescheduling drugs. It also establishes maximum penalties for the criminal manufacture or distribution of scheduled drugs.

Increases in per capita alcohol consumption as well as increased use of illegal drugs during the 1960s raised public concern regarding alcohol and other drug problems. Prevention issues gained prominence on the national level with the creation of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in 1971 and the National Institute on Drug Abuse (NIDA) in 1974. In addition to mandates for research and the management of national programs for treatment, both Institutes included prevention components.

To further prevention initiatives at the Federal level, the Anti-Drug Abuse Act of 1986 created the U.S. Office for Substance Abuse Prevention (OSAP), which consolidated alcohol and other drug prevention activities under the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). The ADAMHA block grant mandate called for States to set aside 21 percent of the alcohol and drug funds for prevention. In a 1992 reorganization, OSAP was changed to the Center for Substance Abuse Prevention (CSAP), part of the new SAMHSA, retaining its major program areas, while the research institutes of NIAAA and NIDA transferred to NIH.

The Office of National Drug Control Policy (ONDCP) was established by the Anti-Drug Abuse Act of 1988. Its primary objective was to develop a drug control policy that included roles for the public and private sector to “restore order and security to American neighborhoods, to dismantle drug trafficking organizations, to help people break the habit of drug use, and to prevent those who have never used illegal drugs from starting.” In early 1992 underage alcohol use was included among the drugs to be addressed by ONDCP.

While Federal, State, and local governments play a substantial role in promoting prevention agendas, much of the activity takes place at grass roots community levels. In addition to funding from CSAP’s “Community Partnerships” grant program, groups receive support from private sources, such as The Robert Wood Johnson “Fighting Back” program.

While alcohol and other drug problems continue to plague the Nation at intolerably high levels, progress is being made. National surveys document a decline in illicit drug use and a leveling off of alcohol consumption. And indicators of problem levels, such as alcohol-involved traffic crashes, show significant declines.

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Impaired Driving. Impaired driving occurs when a person operates a motor vehicle while under the influence of alcohol or other drugs. It is estimated that two in every five Americans will be involved in an alcohol-related crash at some time in their lives. Numbers are not available for other drug-related fatalities, but studies indicate that marijuana and other drugs also affect judgment and motor functions, making driving under the influence of drugs other than alcohol dangerous.

While alcohol-related crashes are declining, their number remains unacceptably high. Approximately 500,000 persons per year are injured in alcohol-related crashes. On average, one person is injured every minute. While there were 19,900 alcohol-related traffic deaths in 1991, that was a decline of 9.9 percent from 1990. During that same year, the number of alcohol-involved drivers in fatal crashes also decreased 10.7 percent. The reduction of deaths associated with alcohol-related traffic crashes has already exceeded the national health objective for the year 2000.

Much of the reduction in crashes related to impaired driving are a result of prevention initiatives at the Federal, State, and community levels. They include raising the minimum alcohol purchase age laws, raising alcohol prices, lowering blood alcohol concentration limits, administrative license revocation, establishing roadside sobriety checkpoints, implementing designated driver programs, developing responsible alcoholic beverage service programs, and starting voluntary youth programs.

Raising Minimum Drinking Age Laws

Since 1988 the national minimum purchase age for alcoholic beverages has been 21. Because of that change in alcohol policy, thousands of young people are alive today who would otherwise have died in traffic crashes. Research findings on the impact on traffic crashes of both lowering and raising the drinking age prompted the Presidential Commission on Drunk Driving to recommend in 1982 that the uniform legal minimum purchase age in the United States be 21. In 1987, Federal legislation was passed to withhold highway construction funds from States that did not adopt a minimum purchase age of 21 years old. By 1988, all States had conformed to the Federal legislation.

Despite reductions in alcohol-related crashes, young people remain especially vulnerable to the threat of alcohol- and other drug-impaired drivers and driving. Traffic crashes are the leading killer of young people, and of these crashes, more than half are alcohol related. In a national survey, nearly half of 10th graders and a third of 8th graders reported having ridden during the past month with a driver who had used alcohol or other drugs before taking the wheel.

Raising Alcohol Prices

Healthy People 2000: National Health Promotion and Disease Prevention Objectives notes that changes in price, including Federal, State and local taxes, may affect both alcohol consumption patterns and alcohol-involved automobile crashes. Evidence about the association

between price and alcohol consumption comes from the results of natural experiments (e.g., comparisons of alcohol consumption in States with differing taxes on alcohol), as well as from econometric research using available data to make projections about the possible impact of price changes on consumption and alcohol use problems through statistical modeling. While reducing impaired driving through raising alcohol prices by taxation or other means has been opposed for financial reasons, it appears that higher alcohol prices lead to fewer impaired driving crashes, as well as to less alcohol consumption by underage youth. It has been projected that nationwide, over 1,000 lives of 18 to 20 year olds could be saved annually if the Federal excise tax were indexed to inflation.

In terms of fatal car crashes, a tax amounting to approximately 35 percent of the retail price of beer would be expected to cut the number of alcohol-related crash deaths among 16 to 21 year olds by about 50 percent. The effect of increased prices on reducing alcohol consumption and alcohol-impaired driving, especially for young people, resulted in a recommendation for increased alcohol taxes by the *Surgeon General's Workshop on Drunk Driving* in 1988.

Lowering BAC Limits

The legal intoxication level in most States is 0.10 percent blood alcohol concentration (BAC). But alcohol depresses the central nervous system, causing slowed reactions, and one's ability to drive is affected long before a BAC of 0.10 is reached. Therefore, many States are considering lowering their BAC limits as a prevention measure. Five States have already reduced BAC limits to 0.08. States are not alone in their concern; the Swedish Parliament voted in 1990 to lower their legal BAC limit to 0.02 percent.

Lower BAC limits could be a powerful tool to prevent alcohol-impaired driving. *Healthy People 2000* recommends BAC limits of 0.04 percent for drivers 21 and over, and 0.00 for drivers under 21. Those States that have adopted lower BAC limits for minors have already experienced decreases in fatalities among this age group.

Administrative License Revocation

Administrative license revocation (ALR) allows an arresting officer to immediately confiscate the driver's license of a driver who is found with a BAC at or above the legally set limit or who refuses to take a BAC test. The officer usually then issues a temporary driving permit valid for a short time, often from 15 to 20 days, and notifies the offender of his or her right to an administrative hearing to appeal the revocation. If there is no appeal, or if the revocation is upheld, the offender loses his or her driving license for a set period (90 days in most States for a first offense, longer for subsequent offenses). By April 1993, ALR laws had been enacted in 33 States and the District of Columbia.

Research shows that ALR laws can prevent impaired driving. One study found that ALR laws reduced night-time fatal traffic crashes (which are likely to involve alcohol) by about 9 percent. For more information about ALR

laws, call the National Highway Traffic Safety Administration at (202)366-2722 or the National Transportation Safety Board at (202)382-6810.

Roadside Sobriety Checkpoints

The practice of setting up police roadblocks to check for alcohol-impaired drivers does deter drinking and driving. A review of nine case studies on the use of sobriety checkpoints found that the evidence shows checkpoints to be “capable of reducing the extent of drunk driving and of death and injuries on the highways.”

Contrary to popular perception, checkpoints are not predominantly intended to catch alcohol-impaired drivers. Rather, their purpose is to deter alcohol-impaired driving by creating the public perception that impaired drivers are likely to be caught and punished for the offense.

Checkpoint programs do this by multiplying the occasions of interaction between the driving public and law enforcement personnel, as well as freeing up the interaction from a link to driving errors.

Experience with sobriety checkpoints in the United States is relatively limited reflecting concerns with the constitutionality of stopping motorists at random. But in 1990, the U.S. Supreme Court decided that such activities did not violate the Constitution.

To maximize the deterrent effect of checkpoints, the nature and purpose of the checkpoints need to be made clear to the public. In addition checkpoints must be conducted frequently and receive adequate media attention, and they must be included within the context of a wider enforcement strategy.

Designated Driver Programs

The designated driver concept encourages individuals who drink alcoholic beverages with companions to designate one member of the group to abstain from alcohol in order to drive the other group members to their destinations. By encouraging drivers to remain alcohol-free, the designated driver both promotes a social norm of not mixing alcohol with driving and fosters the legitimacy of the nondrinking role. Moreover, the concept of no alcohol for the driver is more stringent than current State driving under the influence (DUI) laws permitting some alcohol for drivers.

Survey data show substantial public knowledge, approval, and use of designated drivers. A 1991 Roper Poll found that 37 percent of adults report that they have served as a designated driver, while a 1991 Gallup Poll found that 58 percent of respondents indicated that either they or their friends assigned a designated driver.

While the public has supported the designated driver concept, its effectiveness in reducing impaired driving has not been evaluated. In addition, some have suggested that designated drivers may encourage increased drinking among those who are not driving. However, the Roper and Gallup survey data suggest that the designated driver concept may hold

promise. Until the effectiveness of the designated driver concept is determined, the National Highway Traffic Safety Administration (NHTSA) and CSAP encourage the use of designated drivers by the public and designated driver programs by servers of alcoholic beverages.

Responsible Beverage Service Programs

Programs to promote the responsible service of alcoholic beverages are intended to change the environment surrounding drinking, in both commercial establishments and private parties, to reduce underage sales and the risk of intoxication. As part of these programs, establishments practice strict age identification, discourage intoxication, improve service to the customer, and provide attractive non-alcoholic alternative beverages.

Some States, including Oregon, have laws requiring all those serving alcoholic beverages to be trained. Other areas rely on cooperative agreements between the hospitality industry and the health and safety community to promote voluntary training.

Voluntary Youth Programs

It is important for youth prevention programs to present clear messages, with the central message that no one under 21 should drink alcohol, and no one should use other drugs. However, many popular programs with mixed messages have been encouraged by well-meaning school administrators, community groups, and even Federal agencies. Examples of prevention programs for teenagers that do not give clear abstinence messages are those that distribute BAC charts; parent-child contracts that agree that "no questions will be asked" if the child drinks; and programs or materials that encourage youth to make "responsible decisions" in regard to alcohol and other drugs without making it clear that the only acceptable decision for youth is to abstain.

A large percentage of high school students are binge drinkers, with over one-third reporting the consumption of five or more drinks in a row on at least one occasion in the past 2 weeks. Making it easier for these youths to travel or guaranteeing no questions will be asked by parents is enabling rather than helping them. Consequently, clear "no use" messages are recommended for all voluntary youth programs.

REFERENCES

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- Safer Streets Ahead* (1990) PH292
- Commitment, Communication, Cooperation: Traffic Safety and Public Health Working Together to Prevent Traffic Injury*. Washington, DC: National Highway Traffic Safety Administration (1993)

Labeling Youth. The practice of labeling some young people as “high risk” may have unintended negative consequences for prevention. According to the *Seventh Special Report to the U.S. Congress on Alcohol and Health*, published by the Department of Health and Human Services, one study demonstrated that influencing teachers’ expectations about students by labeling children as intellectually “blooming” had positive effects on these students’ performances (as measured by an intelligence test) that were independent of the students’ actual aptitudes. Negative labels may also influence expectations and result in detrimental effects.

For prevention practitioners it is important to remember that the concept of risk involves relative probabilities for various outcomes, not certainties. In other words, some youth not considered to be at high risk will develop serious alcohol, tobacco, and other drug problems, just as some who are considered to be at high risk will avoid problem use, even without intervention.

The potential labeling problem deserves special attention to protect the interests of the youth involved in any prevention effort. As noted in *Stopping Alcohol and Other Drug Use Before It Starts: The Future of Prevention. CSAP Prevention Monograph 1* many youth in high-risk environments have other problem behaviors (such as school failure, truancy, rebelliousness, and delinquency) that have resulted in them being labeled as troublemakers at school and by their families. Would the addition of the label “at high risk” for alcohol, tobacco, and other drug problems set them further apart from other youth?

The risk of labeling youth, even with the intention of furthering their best interests, is unknown at this time. However, research has shown that labeling adults as “mental patients” and “alcoholics” has negative effects.

Only a few studies have examined the effects of an “at risk” label. In one, men who were at risk for developing heart disease who were frequently reminded of their risk status and given suggestions on coping strategies reported more efforts to change risk factors (e.g., smoking, diet) than men who were given standard medical care. Still, it is not known if these findings can be generalized to youth at special risk of developing alcohol, tobacco, or other drug problems.

The Center for Substance Abuse Prevention (CSAP) suggests that the term “youth in high-risk environments” be used. It avoids stigmatizing young people and emphasizes the critical role environmental factors play in the development of alcohol, tobacco, and other drug problems among youth.

In summary, the concept of risk needs to be understood as helpful but limited. By the same token, care must be taken that the risk of potential alcohol, tobacco, and other drug problems does not become a self-fulfilling prophecy.

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Prevention Resource Guide: Elementary Youth (1991) MS421
Prevention Resource Guide: Secondary School Students (1991) MS423

Marijuana. Marijuana is a harmful drug. The dangers of smoking marijuana are much more serious than they were in the 1960s, especially since the potency of the marijuana now available has increased more than 275 percent over the last decade.

Preliminary studies have shown chronic lung disease in some marijuana users. There are more known cancer-causing agents in marijuana smoke than in cigarette smoke. In fact, because marijuana smokers try to hold the smoke in their lungs as long as possible, one marijuana cigarette can be as damaging to the lungs as four tobacco cigarettes.

Even small doses of marijuana can impair memory function, distort perception, hamper judgment, and diminish motor skills. Health effects also include accelerated heartbeat and, in some persons, increased blood pressure. These changes pose health risks for anyone, but particularly for people with abnormal heart and circulatory conditions, such as high blood pressure and hardening of the arteries.

More important, there is increasing concern about how marijuana use by children and adolescents may affect both their short- and long-term development. Mood changes occur with the first use. Observers in clinical settings have noted increased apathy, loss of ambition, loss of effectiveness, diminished ability to carryout long-term plans, difficulty in concentrating, and a decline in school or work performance. Many teenagers who end up in drug treatment programs started using marijuana at an early age.

Driving under the influence of marijuana is especially dangerous. Marijuana impairs driving skills for at least 4 to 6 hours after smoking a single cigarette. When marijuana is used in combination with alcohol, driving skills become even more impaired.

REFERENCE

What You Can Do About Drug Use in America (1991) PHD587

Media Advocacy. For many years the main role of the media for preventing alcohol, tobacco, and other drug problems has been to build general awareness of the problem and to direct messages at the individual to change behavior regarding alcohol, tobacco, and other drug use. Media advocacy, however, shifts the message from individual behavior change to collective behavior change; that is, to norms and policies.

A working definition of media advocacy is “the strategic use of media as a resource for advancing a social or public policy initiative.” This contrasts substantially with the traditional mass media approach which focuses on individual behavior.

As an example, a few years ago community members were concerned about an announcement at an Oakland Athletics baseball game about a promotion for Bud Lite at a future game. Small flashlights with Bud Lite inscribed on them would be given away to anyone who came to the ballpark who was 16 years of age or older although the legal drinking age is 21.

Community members decided to challenge Anheuser-Busch for promoting this particular product to underage youth through the use of a novelty item—Bud Lite flashlights. Using contacts with the media they raised public concern about the beer promotion and Anheuser-Busch canceled its planned giveaway.

This is one way of focusing on alcohol policy through the media in a way that contrasts with the traditional focus on behavior change. It focused public attention on the policy issues. The question was, shouldn't the alcohol industry know when to say "when" in their efforts to promote alcohol to underage youth?

In media advocacy, challenging conventional wisdom and public thinking is important. Mass media become the arena for contesting public policies and for shifting emphasis from individual behavior change to collective behavior change and policies. Media advocates ask themselves how a media opportunity can best advance policy goals and shift the debate from individuals to the collective decisions of policies and norms.

Using contacts with electronic or print media editors and reporters, advocates can generate public interest in changing industry promotional practices, media policies, tax laws, law enforcement practices, labeling laws, school rules, workplace policies, health care policies, community norms, or other factors that may contribute to youth alcohol, tobacco, and other drug use.

Reporters may not be aware of factors in their communities that promote alcohol, tobacco, and other drug use. By using specific media-related skills, prevention practitioners can provide them with interesting information and stories that further prevention agendas. Those skills include research, creative use of epidemiology and statistics, issue framing, and gaining access to media outlets.

Research

It is important for those using media advocacy to have current, relevant facts and figures on hand and be able to discuss their implications for alcohol, tobacco, and other drug issues. Reporters and editors are more likely to contact people they know who have access to reliable facts when they are researching a story. It is important to be able to back up positions with concrete information and data.

Solid research in the alcohol, tobacco, and other drug field is readily available to prevention practitioners interested in media advocacy. One major resource is the Center for Substance Abuse Prevention's National Clearinghouse for Alcohol and Drug Information (NCADI). By calling 1-800-729-6686, prevention practitioners can obtain resource manuals, monographs, articles, and literature searches on any related topic. At the State level, RADAR Network Centers serve as local information clearinghouses. RADAR Network Centers can be located by calling NCADI.

In addition to gathering research on topics of specific interest, media advocates must also understand how local media operates. Which reporters are most likely to cover health issues? What are the names of relevant news editors? Who should receive a news release? This information can be obtained by studying local media outlets and by telephoning the news departments and asking for names. Learning how the media prefers to receive information pays off by making the media advocate appear more professional and, therefore, more trustworthy.

Creative Use of Epidemiology and Other Statistical Data

The creative use of epidemiology and other statistical data is actually a strategy. It involves taking the research gathered and translating it from often dry or bewildering facts and figures into attention-grabbing news. News must have some immediate relevance. In other words, facts must not only be correct, they should be presented in a way that brings the issue home to the reader.

For example, the fact that the 12 million U.S. college students annually consume over 430 million gallons of alcoholic beverages is not particularly attention grabbing. Using a creative transformation the data can be communicated this way:

The total alcohol consumption of college students exceeds the volume of an Olympic-size swimming pool for every one of the 3,500 colleges and universities in the United States.

This image enables the public to visualize how much students on local college campuses are drinking. They might think about the fact that a swimming pool would hold a tremendous amount of alcohol. Next they might wonder what the college presidents and other officials are doing about student drinking. This kind of transformation can help to capture the attention of reporters, and ultimately the decision-influencing public and opinion leaders.

Framing the Issue

Like the creative transformation of data, framing the issue, or influencing the terms of the debate, is really a strategy. With any issue, both sides attempt to frame the issue to make their positions seem most reasonable. For example, when media advocates point out that advertising alcoholic beverages to vulnerable populations should be limited by law, the alcoholic beverage industry attempts to frame their position in civic terms. The debate shifts from “Should children be targeted by beer companies?” to “Should beer companies have their First Amendment rights protected?”

In addition to framing the issues, the alcoholic beverage industry tries to frame itself in a positive light—presenting itself as supporter of sporting events, patron of local and national artistic endeavors, prevention educator of youth, and protector of freedoms.

According to Lawrence Wallack, Dr.PH, a professor at the School of Public Health, University of California at Berkeley, prevention practitioners have two means of reframing issues that the industry has framed to its own advantage. First, they can focus attention on promotional practices in the environment as the primary problem, not the behavior of individuals who drink. Second, they can address industry practices that appear unethical.

Gaining Access to the Media

Gaining access to the media involves watching for opportunities to contact the media with timely information. Contact may be established through a news release (with a follow-up telephone call), a letter to the editor, a guest editorial, or a telephone call to build interest in a story angle. Over time, media advocates can build credibility so that the media will contact them first when the possibility of an alcohol- or other drug-related story arises.

Gaining access to the media can help groups gain community support for their efforts. For example, when SeaWorld in San Diego, California, owned by Anheuser-Busch, announced its intention to open a hospitality center where adult park patrons could get two free glasses of beer, prevention practitioners used media advocacy techniques to bring their concerns to the attention of the public. The resulting media coverage led to other groups and individuals joining a prevention coalition to continue SeaWorld protests and address other environmental issues.

REFERENCES

- Youth and Drugs: Society's Mixed Messages: CSAP Prevention Monograph 6* (1990) BK172
- Tackling Alcohol Problems on Campus: Tools for Media Advocacy* (1992) BK206

Mutual Self-Help Groups. Mutual self-help groups are based on the premise that sharing with others who have similar problems can be emotionally healing for people with alcohol, tobacco, and other drug problems, including family members and friends. Also, people who have experienced similar problems can be among the best sources for referrals, advice, and moral support. The following are some of the major self-help groups, many of which are available in most communities:

Adult Children of Alcoholics (ACOA). ACOA groups are for adults whose parents and/or grandparents had or currently have alcohol problems. Contact Adult Children of Alcoholics (ACA) World Services, P.O. Box 3216, Torrance, CA 90505, (310)534-1815. For a printed ACA meeting guide, send a legal size self-addressed stamped envelop. Information is also available through Al-Anon Family Groups (see below). Children of alcoholics may also be interested in the activities of the National Association for Children of Alcoholics (NACoA). NACoA is a national nonprofit organization that is a resource for children of alcoholics of all ages. NACoA may be contacted at 11426 Rockville Pike, Suite 100, Rockville, MD 20852, (301)468-0985.

Al-Anon Family Groups. Al-Anon Family Groups include Al-Anon for adult family members and friends of alcoholics, Al-Anon Adult Children Groups for adult children of alcoholics, and Alateen for youthful family members of alcoholics. Local groups are listed in most telephone directories. The headquarters of Al-Anon is at P.O. Box 862, Mid-town Station, New York, NY 10018-0862, (212)302-7240 and 1-800-356-9996.

Alcoholics Anonymous (AA). AA is for alcoholics who want to stop drinking and regain sobriety. AA has more than one million members in 114 countries. Through AA's 12 Steps of recovery and participation in a group, members uphold that (1) they are willing to accept help, (2) self-examination is critical, (3) the admission of personal shortcomings to another individual is necessary, and (4) helping peers through this process helps their personal growth and recovery. Local groups are listed in most telephone directories under "alcohol" or "alcoholism" in the yellow pages. The world headquarters may be contacted at P.O. Box 459, Grand Central Station, New York, NY 10163, (212)686-1100.

COCANON Family Groups. People whose lives have been affected by a friend or family member's cocaine habit may benefit from COCANON. These groups are organized into local chapters, which are often listed in the telephone book. They exist to help families of drug users rather than users themselves. In the groups, members share experiences and common concerns and work to increase their understanding of how the drug problem affects them. The address of COCANON Family Groups is P.O. Box 64742-66, Los Angeles, CA 90064, or call (213)859-2206.

Families Anonymous, Inc. (FA). FA is for families facing alcohol and other drug problems. FA is a group of concerned relatives and friends "who have faced up to the reality that the problems of someone close to us are seriously affecting our lives and our ability to function normally." Based on

the 12 Steps of Alcoholics Anonymous, the organization was formed primarily for persons concerned about alcohol and other drug problems of a family member, especially children. Over the years, it has expanded to include concern about related behavioral problems, including hostility, truancy, and running away. FA may be contacted at P.O. Box 528, Van Nuys, CA 91408, (818)989-7841.

Nar-Anon Family Groups. This group is a companion, but separate, program to Narcotics Anonymous. It is for family members of those with drug problems. They learn to view addiction as a disease, reduce family tension, and encourage the drug user to seek help. Contact Nar-Anon World Service Office at P.O. Box 2562, Palos Verdes Peninsula, CA 90274, (213)547-5800.

Narcotics Anonymous (NA). NA is a mutual self-help program based on the 12 Steps of Alcoholics Anonymous. NA members are "men and women for whom drugs had become a major problem." It is a program of complete abstinence from all mind-altering drugs. If a local group is not listed in your telephone directory, the World Service Office can provide information by writing to P.O. Box 9999, Van Nuys, CA 91409, or calling (818)780-3951.

Rational Recovery. Rational Recovery is a mutual self-help group for alcohol and other drug problems that uses a mental health approach based on rational emotive therapy. Most people attend meetings for a year and, unlike AA, don't identify themselves as powerless over alcohol. Following the principles described in *The Small Book* by Jack Trimpey, members learn mental health tools to change their thinking. Nationwide, groups are now available in about 500 cities. Groups are also available in Canada, Australia, Japan, Panama, and the U.S. Virgin Islands. For additional information write to Rational Recovery, P.O. Box 800, Lotus, CA 95651-0800 or call (916)621-4374 to obtain a local contact.

Women for Sobriety, Inc. (WFS). WFS is a national organization with local units that address the specific needs of women with alcohol-related problems. The program can be used in combination with other alcohol treatment programs or as an alternative to other mutual-help groups. Consult the telephone listings for a local unit, or contact Women for Sobriety, Inc. at P.O. Box 618, Quakertown, PA 18951, (215)536-8026.

Mutual self-help groups have a long history of helping people experiencing problems related to their own or others alcohol and other drug use. Often they are included as part of formal treatment programs, but participation in formal treatment services is not required. Many participate in mutual self-help groups to support lifelong recovery from alcohol and other drug problems. Groups are located in most communities, and are usually free of charge, relying on donations alone to offset expenses, such as meeting room space.

REFERENCES

If Someone Close Has a Problem with Alcohol or Other Drugs (1992) PH317
Moving Forward: Leaving Alcohol and Other Drugs Behind (1993) PHD626

NCADI. CSAP's National Clearinghouse for Alcohol and Drug Information (NCADI) is the information service of the Center for Substance Abuse Prevention of the U.S. Department of Health and Human Services. It acts as the central point within the Federal Government for current print and audiovisual materials about alcohol, tobacco, and other drug problems.

NCADI responds to more than 18,000 telephone and mail inquiries each month and distributes approximately 18 million printed items a year. In addition, special media outreach efforts have allowed CSAP to reach more than 100 million persons annually through NCADI. Almost all publications are available without charge to the public.

Specific NCADI services available to the public include the following:

- *Information and Referral.* The public may call toll-free 1-800-729-6686 or write NCADI, P.O. Box 2345, Rockville, MD 20847-2345, with specific questions about alcohol, tobacco, and other drugs, prevention, demographics, research, or resources. Information specialists are available 8 a.m. to 8 p.m., Eastern Standard Time, Monday through Friday, or callers may leave voice mail messages after hours. Some questions can be answered over the telephone, while others might result in mailing a publication containing the latest information. Other needs may best be met by a computer search of NCADI's data base. In this case, the caller receives a printout of all research abstracts in the data base on the specific area of interest.
- *Adaptable Materials.* Most of the materials distributed by NCADI can be adapted for use at the community level. Fact sheets, brochures, pamphlets, posters, and other materials are available for reprinting and repackaging.
- *Technical Support.* When possible, NCADI offers support to organizations through a wide range of resource lists, direct mail, editorial support, exhibits, and dissemination of materials for conferences.
- *Resources.* Grant announcements and application kits for CSAP, CSAT, NIDA, and NIAAA grants, as well as publications detailing how resources may be obtained, are available from NCADI.
- *Video Resource Program.* NCADI maintains a collection of videotapes that are available for a small handling fee. Videotapes selected for this program are from Federal agencies and private sector groups, and conform to sound public health policy.

- *Prevention Pipeline*. NCADI publishes this bimonthly information service, providing current, comprehensive information about the prevention field. Each issue contains updates on CSAP's program activities; news about prevention efforts at the Federal, State, and local levels; tips for getting prevention stories in the news; expanded coverage of a current issue, such as college drinking; reprints of articles of topical interest; summaries of research findings with immediate program application; abstracts of key research findings; descriptions of new videotape and print materials; and listings of conferences. Subscriptions to *Prevention Pipeline* are \$20.
- *RADAR Network Centers*. NCADI coordinates CSAP's Regional Alcohol and Drug Awareness Resource (RADAR) Network Centers, which operate in every State and U.S. Territory. RADAR Network Centers perform many of the same services of NCADI, and have expertise on activities and resources at the State, and often local levels.

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MS219

Older Adults. While alcohol and other drug use generally declines as people grow older, problems with alcohol and other drugs among older adults (people age 60 and older) is a source of risk to health and safety for many and a serious concern to their families. With the “graying of America” as the baby boom population ages the problem will loom larger on the social agenda.

The number of older adults in the United States doubled between 1950 and 1980. Eleven percent of the current U.S. population is over 60, and by the year 2030, one out of every four Americans will be 60 or over.

Studies have documented the phenomenon known as “late-onset” alcohol problems. In one clinical study, at least 41 percent of the people age 65 and older who were enrolled in a Mayo Clinic alcohol treatment program reported alcohol problems that began after age 60. Data on late-onset alcohol problems in other studies provide further evidence that one’s alcohol consumption may not be consistent across time; some people may actually increase their consumption as a response to age-related stresses, such as loss of employment, widowhood, or other bereavement.

In addition, the changing metabolism that goes with aging can make older people more susceptible to the effects of alcohol. Those who consider themselves moderate drinkers in earlier years may find that consuming the same amounts of alcohol leads to trouble as they grow older. And alcohol problems are compounded by other drug use. Mixing alcohol with over-the-counter or prescription drugs is a common trap for older Americans, and one that can be fatal.

Older adults with alcohol problems often have a high incidence of illnesses and problems not caused by alcohol. Among these are chronic obstructive pulmonary disease, peptic ulcer disease, psoriasis, tobacco dependence, organic brain syndrome, affective disorder, and abuse of or dependence on legal prescription drugs. The potential for drug interactions increases with greater reliance on prescription drugs, multiple prescriptions, difficulty in correct self-administration, and age-related changes in physiology.

In 1988 the Surgeon General’s Workshop on Health Promotion and Aging made a series of recommendations to respond to alcohol and other drug problems among older adults, including: the need for those working with older adults to be informed about the potential for alcohol abuse among their clients; increased training for physicians and health professionals on patterns of alcohol use by older adults; availability of community-based, rather than hospital-based recovery programs; and increased research on the needs of older drinkers.

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Seniors and Alcohol and Seniors and Drugs, Anoka, MN: Minnesota Prevention Resource Center (1992)

Parents and Prevention. A Louis Harris survey of community leaders, grant makers, and prevention experts reports that youthful alcohol and other drug use continues to command center stage as the foremost problem affecting young people and their families. More than 90 percent of those surveyed rated alcohol and other drugs as more threatening than crime, suicide, school dropouts, unemployment, and cigarette smoking. The survey also revealed that almost 75 percent of the respondents expect parents to take a dominant role in dealing with alcohol and other drug use by their children.

Research confirms the importance of the role of parents. Numerous studies indicate that parental attitudes and practices related to alcohol are the strongest social influence on children's use of alcohol and other drugs. Moreover, the nature of the interaction between parent and child has been found to be a key factor in predicting adolescent initiation into alcohol, tobacco, and other drug use. But parents need help. The widespread availability to youth of alcohol, tobacco, and other drugs is a relatively new phenomenon, posing challenges that are in some ways unique to this generation of parents, many of whom are not yet aware of the significant role they can play in preventing alcohol, tobacco, and other drug use by their children.

According to *Communicating About Alcohol and Other Drugs: Strategies for Reaching Populations at Risk*, CSAP Prevention Monograph 5 parents in the general population:

- Believe that alcohol and other drugs are a national problem but may be unaware that their own children are at risk.
- May be unaware that their own children are exposed to alcohol and other drugs at an early age.
- May have little information about specific drugs and their effects.
- May find it difficult to talk to their children about drugs.
- May think their children do not have the money for drugs.
- May accept limited drug use among adults.
- Usually abstain from drug use or excessive alcohol use.
- Believe parents should take the lead in preventing drug use by their own children.

The role of parents of children ages 8 to 12 is especially important because children in this age group generally have nonuse attitudes and behaviors that can be reinforced. Waiting until after they reach the age when they are more easily influenced by peers or after they have started using alcohol, tobacco, or other drugs makes prevention more difficult. Also, children in this age group may experience their first exposure to alcohol, tobacco, and other drugs. Strong parental support can help them resist first use.

Recommendations for Reaching Parents

There are 12 recommendations in CSAP's *Prevention Monograph 5* for prevention practitioners who want to work with parents:

1. *Take advantage of milestone transitions.* When a child changes grades, moves from elementary to middle school, or joins a school club or team, parents may be particularly aware of the child's new needs that may attend this growth. Because they can be anticipated, milestones may be especially useful to prevention planners. Activities, materials, and messages that relate specifically to the transition should be used. For example, club or team orientation meetings, to which the parents are invited, could include presentations on alcohol, tobacco, and other drugs as they relate to the purposes of the club.

2. *Communicate with parents during other life events.* Prevention practitioners have also identified life events, such as moving or family breakups, as important times to reach parents of 8- to 12-year olds. Again, activities and messages should relate to the specific event. For example, marriage counselors, school counselors, or others could include information on special risks to children during times of parental estrangement, including the risk of using alcohol, tobacco, or other drugs.

3. *Use mini-transitions to communicate with parents.* Relatively minor transitions also offer opportunities to reach parents. For example, a family going on vacation could receive a packet of information from a tourist bureau or a State park that includes materials concerning preventing alcohol, tobacco, and other drug use by young children.

4. *Increase parents' awareness and knowledge of potential risks.* Parents need more information to better understand the probability of alcohol, tobacco, and other drug use by their children; the role of gateway drugs (cigarettes, alcohol, and marijuana); and heredity issues. It is also important for parents to know as much or more about drugs as their children are likely to know, and to be able to recognize the signs and symptoms of alcohol, tobacco, and other drug use. Information about AIDS and its relationship to alcohol and other drug use may heighten parental awareness.

5. *Increase parents' knowledge and understanding of parenting skills.* Parenting skills for the current generation of parents must include communicating with children about alcohol, tobacco, and other drugs. Print materials, such as magazine articles and brochures, may help increase parents' knowledge and understanding about parenting skills. These materials also may emphasize the parents' role as primary prevention agents for their children. However, parenting seminars, religious and school programs, and audiovisual materials may be more valuable because they allow demonstration of roles and parenting techniques.

6. *Develop materials for parents.* While materials exist on certain topics for parents, others need to be developed or adapted from existing materials. Particular attention should be given to materials that fit into parents' often-crowded schedules, such as audiocassettes for cars.

7. *Create resource centers in libraries.* Special areas in public libraries could be set aside for a variety of print and audiovisual educational materials on alcohol, tobacco, and other drug issues.

8. *Create resource packets for intermediaries to distribute.* Intermediaries that have access to parents during transitions might be persuaded to distribute packets of information, particularly if the packet included space for the intermediary's own logo, name, and other information.

9. *Use intermediaries having direct access to parents in transitions.* Schools, employers, businesses, and services that come into direct contact with parents during these times could be considered as channels for messages concerning alcohol, tobacco, and other drug use by youth.

10. *Work with local media.* Media attention such as a feature article on record shops that sell paraphernalia, a talk show with a school principal discussing drugs in a local elementary school, a news segment on playground drug markets, or a story about the activities of a Just Say No Club can help overcome parental ignorance or denial.

11. *Influence the mass media to help reach parents.* Print and broadcast reporters cover issues they consider newsworthy. Prevention practitioners can provide new angles on alcohol, tobacco, and other drug use issues, suggest story lines for shows, or praise appropriate coverage as it occurs.

12. *Conduct research on the knowledge, attitudes, and practices of parents.* There is a serious lack of data on the knowledge, attitudes, and practices of parents of children at moderate risk. Such data need to be updated frequently as alcohol, tobacco, and other drug use patterns change.

Parenting today poses different challenges than for previous generations due to major societal changes, such as the changing roles of men and women, the greater mobility of families, and the expanding influence of mass media.

Parents may not head troubled families or live in high-risk communities, but their children are still vulnerable to problems associated with alcohol, tobacco, and other drug use. Researchers and other experts confirm that all families need assistance in the area of prevention.

REFERENCES

- Parent Training Is Prevention* (1992) BK184
What You Can Do About Drug Use in America (1991) PHD587
Young Teens: Who They Are and How to Communicate with Them About Alcohol and Other Drugs (1991) PH306
Communicating About Alcohol and Other Drugs: Strategies for Reaching Populations at Risk. CSAP Prevention Monograph 5(1992) BK170
Parental Awareness and Responsibility, St. Petersburg, FL: Operation PAR (1993) PHD611
Developing the Resilient Child, The Northeast Regional Center for Drug-Free Schools and Communities (1992)

PCP. PCP is a hallucinogenic drug that alters sensation, mood, and consciousness and distorts hearing, touch, smell, taste, and vision. It is legitimately used as an anaesthetic for animals. When used by humans, PCP induces a profound departure from reality, which leaves the user capable of bizarre behavior and severe disorientation. These PCP-induced effects may lead to serious injuries or death to the user while under the influence of the drug.

PCP produces feelings of mental depression in some individuals. When PCP is used regularly, memory, perception functions, concentration, and judgment are often disturbed. Used chronically, PCP may lead to permanent changes in cognitive ability (thinking), memory, and fine motor function.

Mothers who use PCP during pregnancy often deliver babies who have visual, auditory, and motor disturbances. These babies may also have sudden outbursts of agitation and other rapid changes in awareness similar to the responses in adults intoxicated with PCP

REFERENCE

What You Can Do About Drug Use in America (1991) PHD587

People with Disabilities. The burdens that alcohol, tobacco, and other drug problems pose are compounded when the individual is one of the estimated 43 million Americans who have one or more physical or mental disabilities. For these individuals, the process of recovery is made more difficult by barriers that do not exist for others.

In 1990, Congress passed the Americans with Disabilities Act (ADA), which describes people with disabilities as a “discrete and insular minority who have been subjected to a history of purposeful, unequal treatment and relegated to an inferior status in our society.” Congress noted that people with disabilities face discrimination in employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and access to public services.

Congress passed the ADA to eliminate major forms of discrimination against people with disabilities, including:

- Outright intentional exclusion;
- Overprotective rules and policies;
- Segregation or relegation to lesser services or programs;
- Exclusionary standards; and
- Architectural, transportation, and communication barriers.

Prevention practitioners are affected by the ADA because prevention programs are considered to be public accommodations, regardless of whether they are configured as social services, health care services, or educational services. As of January 26, 1992, program practitioners must permit all people with disabilities to participate in the full and equal enjoyment of goods, services, facilities, privileges, advantages, and accommodations of their programs.

People with disabilities can benefit as a target audience for prevention efforts. According to the Resource Center on Substance Abuse Prevention and Disability, alcohol and other drug problems are significantly more prevalent among people with disabilities. One possible reason for increased problems is that regular use of prescribed medication, both non-psychoactive and psychoactive, may serve to potentiate the effect of drugs such as alcohol. Another reason may be that alcohol, tobacco, and other drug problems that existed prior to the disability tend to continue and worsen.

The Resource Center on Substance Abuse Prevention and Disability recommends the following for including persons with disabilities in prevention or intervention programs:

- Focus on the abilities of people, rather than on disabilities. Be mindful that alternative ways of doing things are often equally effective. Encourage people with disabilities to be their own advocates.

- Make sure that parking areas, restrooms, and buildings where you provide services or conduct meetings are architecturally and environmentally accessible to all people. This is crucial to the establishment of a comfortable and equitable relationship for people with disabilities. Get expert advice before making expensive structural modifications.
- Ask people with disabilities to facilitate disability awareness training sessions with staff to promote positive attitudes. Locate material and have it available for learning more about disability-related issues.
- Involve people with disabilities on advisory boards and planning committees, and include them in the planning and presentation of all sponsored programs. Actively seek qualified people with disabilities when hiring staff.
- Assume responsibility for understanding the issues that affect people with disabilities. Learn more. Send for information from consumer- and disability-related organizations, ask for their support, and invite their representatives to speak at meetings.
- For each person with a disability, explore all possible factors contributing to alcohol, tobacco, and other drug involvement, not just those related to disability.

Additional information is available through the Resource Center on Substance Abuse Prevention and Disability, 1331 F Street, NW, Suite 800, Washington, DC 20077-1514, (Voice 202-783-2900), (TDD 202-737-0725).

REFERENCE

A Look at Alcohol and Other Drug Abuse Prevention and . . . [various topics].
Resource Center on Substance Abuse Prevention and Disability (1991)

Pregnant and Postpartum Women. Problems associated with alcohol, tobacco, and other drug use during pregnancy are well documented in the research literature. CSAP's publication *Alcohol, Tobacco, and Other Drugs May Harm the Unborn* presents recent findings of basic research and clinical studies on the effects of alcohol, tobacco, and other drugs on the unborn, on the mother herself, and on the baby after birth through lactation.

An emerging consensus views alcohol, tobacco, and other drug use during pregnancy as a community problem. Inherent in that view is that services must be developed by community members to create a broad community continuum of services. In addition, services should be not only physically accessible to community members, but also culturally accessible.

Pregnancy provides a strong motivation for alcohol, tobacco, and drug using women to seek help. However, fear of reprisals, legal interventions, and loss of child custody prevents many women from getting help. A policy statement of the National Council on Alcoholism and Drug Dependence (NCADD) states that punitive approaches are "fundamentally unfair to women suffering from addictive diseases and serve to drive them away from seeking both prenatal care and treatment for their alcoholism and drug addictions." NCADD also cites evidence of disparities of screening and reporting of women of color, poor women, and women receiving care in public hospitals to legal authorities to support its position of increasing access to care and decriminalizing governmental responses. Respondents to a NCADD survey of CSAP funded Pregnant and Postpartum Demonstration Projects cited media attention on punitive actions against pregnant women who are alcohol, tobacco, and drug dependent as deterring women from seeking services.

In order to counteract this barrier to services, prevention initiatives directed at pregnant and postpartum women need to enhance the natural motivation of women to have a healthy baby by promoting services as "safe" and confidential.

In addition, prevention strategies that combine information with options for change have shown promising results in reducing the problem of alcohol, tobacco, and other drug use during pregnancy. Much of the impetus behind Federal legislation requiring health warning labels on alcoholic beverage containers was concern that people were not aware that consuming alcohol during pregnancy can cause birth defects. Some States and communities require the posting of warning signs on the risks of drinking during pregnancy at establishments that sell alcoholic beverages.

Other prevention programs to reach women include physician training and outreach to women to help them receive prenatal care. And efforts that recognize the importance of relationships for women can call upon the support of family members and others for alcohol- and other drug-free pregnancies.

Current prevention approaches call for a more integrated system of alcohol, tobacco, and other drug treatment and maternal and child health care. For

example, since 1989 the Women's and Infants Clinic at Boston City Hospital has provided pediatric care, child development services, and drug abuse treatment services in an integrated service system.

For more information, contact the National Resource Center for Prevention of Perinatal Abuse of Alcohol and Other Drugs at (703)218-5600.

REFERENCES

- Alcohol, Tobacco, and Other Drugs May Harm the Unborn* (1992) PH291
Prevention Resource Guide: Pregnant/Postpartum Women and Their Infants (1991) MS420
Alcohol Alert #13. Fetal Alcohol Syndrome (1991) PH297

Prevention. While there is no single definition of prevention there is general agreement among prevention practitioners on the overall goal of prevention. It is to foster a climate in which:

- Alcohol use is acceptable only for those of legal age and only when the risk of adverse consequences is minimal;
- Prescription and over-the-counter drugs are used only for the purposes for which they were intended;
- Other abusable substances (e.g., gasoline or aerosols) are used only for their intended purposes; and
- Illegal drugs and tobacco are not used at all.

The Center for Substance Abuse Prevention (CSAP) has been charged since its inception in 1986 with providing guidance and leadership in the Nation's prevention efforts. As a result of CSAP's efforts, some basic premises regarding prevention have been established:

- Prevention strategies must be comprehensively structured to reduce individual and environmental risk factors and to increase resiliency factors in high-risk populations.
- Community involvement is a necessary component of an effective prevention strategy; a shared relationship among all parties is essential in the promotion of alcohol, tobacco, and other drug prevention efforts.
- Prevention must be intertwined with the general health care and social services delivery systems and it must provide for a full continuum of services.
- Prevention approaches and messages that are tailored to differing population groups are most effective.

Current prevention strategies reflect a relatively new approach that was introduced in the 1970s and expanded in the 1980s. Prevention research has become more sophisticated, with improved evaluation techniques resulting in the development of a scientific basis for prevention efforts. Prevention strategies are evolving as new scientific findings shed light on promising approaches to reducing alcohol, tobacco, and other drug problems.

Since the mid-1980s, the prevention field has developed sophisticated information dissemination and networking systems. A centralized information source is available through CSAP's National Clearinghouse for Alcohol and Drug Information (NCADI). By calling NCADI's toll-free telephone number, prevention practitioners can get answers to their questions and access publications and literature searches. CSAP's RADAR Network Centers operate as an interactive communication system among people at the national, State, and community levels. The RADAR Network allows members around-the-clock access to information, publications,

funding source referrals, and audiovisual materials developed by Federal agencies, Network members, and other organizations.

In summary, prevention has developed into a respected, organized discipline. Prevention offers communities an opportunity to stop alcohol, tobacco, and other drug problems before they start, and provides hope for effecting community change to support healthy behaviors.

REFERENCES

- Prevention Research Findings: 1988 CSAP Prevention Monograph 3* (1990) BK162
- Research, Action, and the Community: Experiences in the Prevention of Alcohol and Other Drug Problems. CSAP Prevention Monograph 4* (1990) BK167
- Prevention Plus II: Tools for Creating and Sustaining a Drug-Free Community* (1991) BK159
- Prevention Plus III: Assessing Alcohol and Other Drug Programs at the School and Community Level* (1991) BK188

Prevention Strategies. Prevention strategies targeting youth have evolved over the past 20 years as evaluation research reveals more about what works. Several strategies are used effectively, especially in combination:

- *Information dissemination.* This strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco, and other drug use, abuse, and addiction and their effects on individuals, families, and communities, as well as information to increase perceptions of risk. It also provides knowledge and awareness of prevention policies, programs, and services. It helps set and reinforce norms (for example, underage drinking and drug dealers will not be tolerated in this neighborhood).
- *Prevention education.* This strategy aims to affect critical life and social skills, including decision making, refusal skills, critical analysis (for example, of media messages), and systematic and judgmental abilities.
- *Alternatives.* This strategy provides for the participation of targeted populations in activities that exclude alcohol, tobacco, and other drug use by youth. Constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by, alcohol, tobacco, and other drug use.
- *Problem identification and referral.* This strategy calls for identification, education, and counseling for those youth who have indulged in age-inappropriate use of tobacco products or alcohol, or who have indulged in the first use of illicit drugs. Activities under this strategy would include screening for tendencies toward substance abuse and referral for preventive treatment for curbing such tendencies.
- *Community-based process.* This strategy aims to enhance the ability of the community to provide prevention and treatment services to alcohol, tobacco, and other drug use disorders more effectively. Activities include organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking. Building healthy communities encourages healthy lifestyle choices.
- *Environmental approach.* This strategy sets up or changes written and unwritten community standards, codes, and attitudes—influencing incidence and prevalence of alcohol, tobacco, and other drug use problems in the general population. Included are laws to restrict availability and access, price increases, and community-wide actions.

REFERENCES

- The Future by Design: A Community Framework for Preventing Alcohol and Other Drug Problems Through a Systems Approach* (1991) BK189
- Frequently Asked Questions about Preventing Alcohol, Tobacco, and Other Drug Problems* (1993) Center for Substance Abuse Prevention

Public Health Model. Because of the nature and magnitude of the problem, few people would disagree that drug abuse is a public health issue. The problem of drug abuse warrants an approach similar to the way any other serious health problem or disease would be addressed.

The public health model can be illustrated by a triangle, with each of the angles representing (1) the host; (2) the agent; and (3) the environment. A public health model, which uses the science of epidemiology, stresses that problems arise through the reciprocal relationships and interactions among the agent, the host, and the environment. In the case of alcohol, tobacco, and other drug problems, the agent is the substance, the host is the individual drinker or drug user, and the environment is the social and physical context of drinking or drug use. Of particular importance to prevention are environmental influences on drinking.

Drug abuse epidemiology is more complicated than communicable disease epidemiology. Therefore, the concept of agent is broadened beyond the “drug” and includes other identified causative factors. “Host” has also been expanded and we often talk about peers or groups as part of this factor. The term “environment” has not changed but with additional research and knowledge its meaning has been enlarged to be more comprehensive.

Primary prevention is the focus of CSAP. Prevention programs in the past, including drug abuse programs, often neglected to deal with the environment. Often they focused exclusively on inoculating the host/individual through educational efforts expecting that information on the risks associated with alcohol, tobacco, and other drug use would be sufficient to prevent use and avoid problems. However, a teenager (host) who attends a well-presented educational seminar on prevention at school may go home to a neighborhood (environment) where use is glamorized on billboards, laws are not enforced, and alcohol, tobacco, and other drug (agent) are plentiful. A public health approach to prevention requires not only an understanding of how the three factors of host, agent, and environment interact, but also include a plan of action for influencing all three.

Influencing the Host

Prevention practitioners can reach people directly through schools, social programs, workplaces, day care centers, religious organizations, and other groups. Health education is a well-known method that often has changing the behavior of individuals as its primary focus.

The earliest prevention programs used information and scare tactics to influence behavioral change. However, studies found that for the most part, youth exposed to these programs alone are no less likely to use alcohol, tobacco, and other drugs than other youth. The common interpretation of these findings is that information alone is insufficient to effect behavioral change. In some instances, such programs may even stimulate curiosity and suggest to young people that their fears about particular drugs are exaggerated.

Scare tactics, while still a part of some education programs, do not appear to be effective in deterring alcohol, tobacco, and other drug use, especially among people who often believe “it won’t happen to me.” However, there is some indication that the highly publicized drug-related death of basketball star Len Bias resulted in an increase in youth perception of the dangers of cocaine.

Efforts to reach the host and his/her peer group typically employ some combination of the following information- and skills-building strategies:

- Developing problem-solving and decision-making skills;
- Increasing self-awareness and self-efficacy;
- Learning non-use skills for dealing with anxiety and stress;
- Enhancing interpersonal skills, such as the ability to express displeasure, anger, and needs; and
- Drawing the relationship between alcohol, tobacco, and other drug use and health concerns.

Strategies for youth in high risk environments are often broadened to include controlling impulses, managing hostility and anger, structuring leisure time, achieving in school, and coping with authority. The research evidence to date has demonstrated that these approaches are at least moderately effective.

Influencing the Agent and Other Causative Factors

The agent in the public health model is the substance. Public health advocates have had some success in influencing legal agents such as alcohol and tobacco. Requiring warning labels on alcoholic beverage containers and cigarette packages and advertising are examples of these successes.

In an effort to influence the agent, protesters mounted a successful campaign against the packaging of Cisco, a high potency wine cooler. Other potential activities for influencing the agent alcohol are advocating changes in the alcoholic content of certain beverages, such as malt liquors, or controls on package sizes, such as liters of wine coolers.

The national “War on Drugs” campaign focused primarily on the agent. A controversial program in the 1970s that sprayed marijuana fields in Mexico with a potent insecticide that made humans ill is another example of focusing on the drug as the agent.

Influencing the Environment

Programs that influence the environment to reinforce healthy behaviors are increasingly part of community-based prevention efforts. Within a public health model, environments include schools, families, neighborhoods, and communities, as well as the broader social and cultural environments that

are influenced by legislation, pricing, advertising, and media portrayals of alcohol, tobacco, and other drug use.

The public health model demonstrates that programs that depend exclusively on teaching the host, altering the agent, or changing the environment oversimplify the complex problem of alcohol, tobacco, and other drug use. Each factor—the agent, host, and environment—must be considered for effective prevention.

REFERENCE

The Future by Design: A Community Framework for Preventing Alcohol and Other Drug Problems Through a Systems Approach (1991) BK189

RADAR Network. The Center for Substance Abuse Prevention (CSAP) established the Regional Alcohol and Drug Awareness Resource (RADAR) Network to make current prevention information readily available to those who need it most—prevention practitioners at the State and community levels.

The RADAR Network responds to the need for prevention services closer to home, staffed by people who understand the unique assets and liabilities of local communities. The RADAR Network was formed in partnership with State governments and national constituency groups. The National Clearinghouse for Alcohol and Drug Information (NCADI) serves as the national center for information and services, but the satellite centers of the RADAR Network provide local support to prevention practitioners and other community members interested in addressing alcohol, tobacco, and other drug problems.

RADAR Network Centers

RADAR Network Centers are located in every State and U.S. Territory. Coordinated through NCADI, regular RADAR Network Centers services are available to all community members. Services include:

- Helping people find accurate and up-to-date information about prevention as well as effective materials and programs that can be adapted for their communities.
- Providing posters, booklets, and other materials with prevention and intervention messages for youth, parents, and other target audiences. Some of these products are offered in bulk for distribution to groups, while others are camera-ready for reproduction. Almost all materials are in the public domain and community members are encouraged to reproduce and distribute copies.
- Promoting and supporting outreach efforts to groups at high risk (e.g., children of alcoholics and other drug abusers, dropouts, pregnant teens, low-income families, juvenile delinquents, youths with disabilities, suicidal teens, and those with mental health problems).
- Responding to questions about prevention and intervention by mail or telephone and assisting visitors by providing hands-on assistance.
- Helping prevention practitioners design and implement programs tailored to meet the special needs of their communities. This includes assistance with services and materials that are culturally sensitive and age-appropriate.

RADAR Network Centers work closely with CSAP, NCADI, CSAP grantees, and each other through an electronic communications system (PREVline) that allows for the ready exchange of information and ideas, facilitating an unprecedented level of interstate cooperation on prevention issues. The system is available 24 hours a day, 7 days a week.

In addition to State RADAR Network Centers designated by State governments, the network includes Specialty RADAR Network Centers that operate at the national level, associate members that work at the community level, and international organizations.

Specialty RADAR Network Centers

Specialty RADAR Network Centers are national organizations and Federal agencies that focus on specific alcohol, tobacco, and other drug issues. For example, National Families in Action might help a caller track how the media is covering a specific alcohol, tobacco, and other drugs related issue.

Associate RADAR Network Members

Associate members are organizations that conduct information and referral services at the community level. In addition to serving the public, associate members assist and support the RADAR Network Centers in their activities.

International RADAR Network Members

Other countries are interested in information exchange with the United States. Some have established International RADAR Network Centers and have sent representatives to NCADI to learn how to set up similar clearinghouse activities.

Using the RADAR Network

Anyone may use the services offered by the RADAR Network. For the location of the nearest RADAR Network Center or for membership information, contact NCADI, P.O. Box 2345, Rockville, MD 20847-2345, or call 1-800-729-6686; TDD 1-800-487-4889.

Resources for Prevention. Many community members who are concerned about alcohol, tobacco, and other drug problems want to do something about them but don't know where to begin. Help is available at the Federal, State, and community levels if one knows where to look.

Government Resources

While numerous Federal agencies play some role in prevention efforts, the Center for Substance Abuse Prevention (CSAP) was established in 1986 as the focus of the U.S. Department of Health and Human Services' efforts to prevent alcohol, tobacco, and other drug problems nationwide. CSAP provides information and assistance to national, regional, State, and community prevention efforts. CSAP stimulates and supports prevention projects nationwide; identifies, develops, and distributes information concerning prevention research and practices; and administers a national training system to increase the knowledge and skills of prevention practitioners. CSAP serves as a catalyst for collaborative efforts among government, corporate, and voluntary organizations at the national, State, and community levels.

CSAP's information arm, CSAP's National Clearinghouse for Alcohol and Drug Information (NCADI) has information specialists available to answer questions, including those regarding resources. They can be reached by calling 1-800-729-6686, or by writing P.O. Box 2345, Rockville, MD 20847-2345.

For a complete list of Federal agencies that may be contacted directly by prevention practitioners, see the section on Federal agencies. These agencies offer various resources, sponsor local prevention initiatives through grant-in-aid programs, develop and disseminate prevention materials and model programs, and conduct information-sharing conferences.

State Resources

All States and U.S. Territories have a single governmental agency responsible for coordinating alcohol, tobacco, and other drug prevention and treatment services. In addition, they have a RADAR Network Center providing varying levels of assistance. Addresses and telephone numbers of State agencies and RADAR Network Centers are available by calling NCADI. In addition, the National Association of State Alcohol and Drug Abuse Directors (NASADAD) can provide information on State resources. The National Prevention Network (NPN) supports networking, resource sharing, and information exchange among State alcohol and other drug prevention professionals and other individuals. Members are appointed by their State or Territory's alcohol and other drug abuse agency. Both NASADAD and NPN are located at 444 N. Capitol Street, NW, Suite 642, Washington, DC 20001.

Community Resources

Resources at the community level range from county health departments mandated to administer local alcohol, tobacco, and other drug prevention and recovery services to task forces or committees of local residents to coordinate prevention initiatives and advise policy makers on how resources should be allocated. Local law enforcement agencies can also serve as prevention resources, providing such services as presentations to parents and youth, school-based programs such as Drug Awareness and Resistance Education (DARE) programs, and neighborhood watch programs.

Other local government agencies that can support prevention efforts are parks and recreation departments, that can assist in the development of alcohol, tobacco, and other drug-free events and recreation; departments of mental health, that can provide information and early intervention services; and alcohol beverage control boards, that can help with programs to prevent sales of alcohol to minors.

Nongovernment Resources

Many national organizations are actively involved in efforts to reduce alcohol, tobacco, and other drug use and related problems. These organizations develop prevention materials, disseminate programs, conduct national media campaigns, lobby for legislation, and provide training and technical assistance. Some provide financial resources to local initiatives. In addition, many have chapters that are active in prevention initiatives in local communities.

Local businesses also have an important role to play in prevention. Businesses can provide support for local efforts in the form of donated materials and services (e.g., printing, art work, paper supplies, reproduction) and by encouraging their employees to act as volunteers.

REFERENCES

- Citizen's Alcohol and Other Drug Prevention Directory: Resources for Getting Involved* (1990) BK171
- State Resources & Services Related to Alcohol and Other Drug Abuse Problems FY 1990* (1992) BK194
- "Network News," bimonthly newsletter of the National Association of State Alcohol and Drug Abuse Directors

Resilience/Protective Factors. Many youths, although living in high-risk environments, seem to possess personal resilience that helps them avoid alcohol, tobacco, and other drug problems. One current challenge to the prevention field is to identify these protective factors and determine how they can be instilled in all youth in high-risk environments.

The following is a checklist of youth protective factors:

1. *Community Environment*

- Middle or upper class
- Low unemployment
- Adequate housing
- Pleasant neighborhood
- Low prevalence of neighborhood crime
- Good school
- School that promotes learning, participation, and responsibility
- High-quality health care
- Easy access to adequate social services
- Flexible social service providers who put clients' needs first

2. *Family Environment*

- Adequate family income
- Structured and nurturing family
- Parents promote learning
- Fewer than four children in family
- Two or more years between the birth of each child
- Few chronic stressful life events
- Multi-generational kinship network
- Non-kin support network, e.g., supportive role models, dependable substitute child care
- Warm, close personal relationship with parent(s) and/or other adult(s)
- Little marital conflict
- Family stability and cohesiveness
- Plenty of attention during first year of life
- Sibling as caretaker/confidante
- Clear behavior guidelines

3. *Constitutional Strengths*

- Adequate early sensorimotor and language development
- High intelligence
- Physically robust
- No emotional or temperamental impairments

4. *Personality of the Child*

- Affectionate/endearing
- Easy temperament
- Autonomous
- Adaptable and flexible
- Positive outlook
- Healthy expectations
- Self-efficacy

Self-discipline
 Internal locus of control
 Problem-solving skills
 Socially adept
 Tolerance of people and situations

If the high-risk environment is the family itself, for instance if children are growing up in an alcoholic or drug abusing family, studies suggest that they have a better chance of growing into healthy adulthood if they:

- Can learn to do one thing well that is valued by themselves, their friends, and their community;
- Are required to be helpful as they grow up;
- Are able to ask for help for themselves;
- Are able to elicit positive responses from others in their environment;
- Are able to distance themselves from their dysfunctional families so that the family is not their sole frame of reference;
- Are able to bond with some socially valued, positive entity, such as the family, school, community groups, or church;
- Are able to interact with a (perceived to be) caring adult who provides consistent caring responses.

Resiliency factors, along with risk factors, need to be more widely publicized for the use of parents, gatekeepers, and prevention planners. While many of the factors listed are the result of external forces, those factors that may be taught or instilled in children can provide some protection to youths at high risk for alcohol, tobacco, or other drug problems.

REFERENCES

- Youth at High Risk for Substance Abuse* (1990) BKD06
Using Community-Wide Collaboration to Foster Resiliency in Kids. A Conceptual Framework. Portland, OR: Northwest Regional Educational Laboratory (1993)

Risk Factors. Risk factors are characteristics that occur statistically more often for those who develop alcohol, tobacco, and other drug problems, either as adolescents or as adults. Recent research points to a considerable number of such factors, including individual, family, and social/cultural characteristics. The following chart from CSAP's publication *Breaking New Ground for Youth at Risk: Program Summaries*. CSAP Technical Report 1 lists these factors:

1. Community Environment

Poverty

Living in an economically depressed area with:

- high unemployment
- inadequate housing
- high prevalence of crime
- high prevalence of illegal drug use

Minority status involving:

- racial discrimination
- culture devalued in American society
- differing generational levels of assimilation
- cultural and language barriers to getting adequate health care and other social services
- low educational levels
- low achievement expectations from society

2. Family Environment

Alcohol, tobacco, and other drug dependency of parent(s)

Parental abuse and neglect of children

Antisocial, sexually deviant, or mentally ill parents

High levels of family stress, including financial strain

Large, overcrowded family

Unemployed or underemployed parents

Parents with little education

Socially isolated parents

Single female parent without family/other support

Family instability

High level of marital and family conflict and/or family violence

Parental absenteeism due to separation, divorce, or death

Lack of family rituals

Inadequate parenting and low parent/child contact

Frequent family moves

3. Constitutional Vulnerability of the Child

Child of an alcohol, tobacco, or other drug abuser

Less than 2 years between the child and its older/younger siblings

Birth defects, including possible neurological and neurochemical dysfunctions

Neuropsychological vulnerabilities

Physically disabled

Physical or mental health problems
Learning disability

4. *Early Behavior Problems*

Aggressiveness combined with shyness
Aggressiveness
Decreased social inhibition
Emotional problems
Inability to express feelings appropriately
Hypersensitivity
Inability to cope with stress
Problems with relationships
Cognitive problems
Low self-esteem
Difficult temperament
Personality characteristics of ego under-control, rapid tempo, inability to delay gratification, overreacting

5. *Adolescent Problems*

School failure and dropout
At risk of dropping out
Delinquency
Violent acts
Gateway drug use
Other drug use and abuse
Early unprotected sexual activity
Teenage pregnancy/teen parenthood
Unemployed or underemployed
At risk of being unemployed
Mental health problems
Suicidal

6. *Negative Adolescent Behavior and Experiences*

Lack of bonding to society (family, school, and community)
Rebelliousness and nonconformity
Resistance to authority
Strong need for independence
Cultural alienation
Fragile ego
Feelings of failure
Present versus future orientation
Hopelessness
Lack of self-confidence
Low self-esteem
Inability to form positive close relationships
Vulnerability to negative peer pressure

It is important to recognize that risk factors are only indicators for the potential of problem occurrence. While they can be helpful in identifying children who are vulnerable to developing alcohol, tobacco, or other drug problems, they are not necessarily predicative for an individual child.

Children growing up under adverse conditions often mature into healthy, well-functioning adults. In addition, the use of risk factors to label children poses its own risk. Consequently, there is increasing attention on those factors that seem to protect children from developing alcohol, tobacco, or other drug problems.

There are no simple solutions for helping youth at high risk for developing alcohol, tobacco, or other drug problems. Reducing risk factors and fostering resiliency are part of a comprehensive approach to prevention, and are consistent with a public health approach to reducing problems.

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Breaking New Ground for Youth at Risk: Program Summaries. CSAP Technical Report 1 (1990) BK163

Youth at High Risk for Substance Abuse (1990) BKD06

Hawkins, J.D., Lishner, D.M.; and Catalano, R.F. "Childhood Predictors and the Prevention of Adolescent Substance Abuse." In *Etiology of Drug Abuse: Implications for Prevention. NIDA Research Monograph 56. A Research Analysis and Utilization System Review Report*, 1985

Rural Communities. Alcohol, tobacco, and other drug problems are not confined to inner-city and suburban environments. Rural communities share both the Nation's problems and its desire to prevent those problems.

Alcohol, tobacco, and other drug use problems in rural communities have not been the focus of a national study since 1981, when the U.S. Department of Health and Human Services concluded that about two-thirds as many rural as non-rural inhabitants would try drugs in their lifetime. That report also suggested that differences between rural and non-rural prevalence rates of drug use were declining.

A 1990 report from the General Accounting Office on rural drug use confirmed that prediction. The study found that total alcohol and other drug use rates in rural States are about as high as those found in non-rural States. Differences were found for cocaine use, which appears to be lower in rural States, and inhalant use, which may be higher in rural States.

The National Institute on Drug Abuse's 1990 High School Senior Survey, *Monitoring the Future*, found that alcohol is the drug of choice for rural high school seniors, which is consistent with national trends. However, rural seniors are more likely to be smokers and use stimulants and inhalants.

Other regional studies confirm the High School Senior Survey, especially regarding alcohol use. Like other communities, alcohol is by far the drug of choice for young people. According to a survey conducted in one small mid-Atlantic town, one-third of rural children had their first drink by age 10. Males drink at earlier ages and more frequently than females, but the girls are catching up. A study of 650 students in one rural town revealed that close to one-half of males had their first drink by age 10 compared with one-fifth of females. By age 14, 82 percent of males and 80 percent of females have had their first drink. Use of tobacco by young people is especially prevalent in rural communities. According to the Centers for Disease Control and Prevention, Office on Smoking and Health, the use of snuff and chewing tobacco by young males has increased in rural areas. Many young males may begin use due to peer pressure and heavy promotional activities by the smokeless tobacco industry, and then become addicted.

Rural areas are often sites for marijuana cultivation and drug laboratories. This contributes to drug availability and can often make prevention efforts more difficult.

While rural communities are not all alike, they do share one common feature: low population density. While alcohol, tobacco, and other drug use itself is a problem shared by rural and urban communities of prevention and treatment efforts, lower population density poses its own set of rural-specific problems. Those problems include a lack of acceptance by the rural community of prevention and treatment efforts, unavailability of trained staff, transportation difficulties, and higher costs. One study found that transportation for rural youths and families is often an insurmountable task.

Certain characteristics of rural communities can aid prevention programs. For example, a study of rural women noted strengths that aid in solving problems, including large networks of family, friends and neighbors, traditions of volunteering and mutual aid, and cultural attitudes and values.

Families are an important part of rural life and can play a major role in preventing alcohol, tobacco, and other drug problems. In addition, several CSAP Community Partnership grantees in rural areas have observed that schools are important settings for prevention efforts.

CSAP's National Clearinghouse for Alcohol and Drug Information has materials available on prevention within rural communities. Also, the Rural RADAR Network Specialty Center, National Rural Institute on Alcohol and Drug Abuse, can provide information and materials on rural alcohol, tobacco, and other drug abuse prevention issues. Its address is National Rural Institute on Alcohol and Drug Abuse, Arts and Sciences Outreach Office, University of Wisconsin-Eau Claire, Eau Claire, WI 54702-4004, (715)836-2031.

REFERENCES

Prevention Resource Guide: Rural Communities (1991) MS416

Edwards, R.W., "Drug and Alcohol Use by Youth in Rural America," *Drugs in Society* 7(1/2):1-8, 1992

Social Bonding. Social bonding is a promising concept for prevention efforts. Some studies have found that young people who establish a bond with societal norms and standards are less likely to use alcohol, tobacco, and other drugs. The elements of social bonding that prevent alcohol, tobacco, and other drug use by youth include:

- Attachment to parents;
- Commitment to school and education;
- Regular involvement in church activities; and
- Belief in the expectations, norms, and values of society.

Conversely, qualities linked to drug use that appear to characterize youth who have not bonded to society include:

- Alienation from the dominant values and norms of society;
- Low religiosity;
- Rebelliousness;
- High tolerance of deviance;
- Resistance to traditional authority; and
- A strong need for independence.

Research on social bonding and the results of field experiences have focused attention on the family, the peer group, the school, and the community as important settings for prevention efforts. The implication is that prevention programs must include all these areas in a comprehensive manner to be effective.

It appears that youths at high risk for alcohol, tobacco, and other drug problems benefit from prevention efforts that focus on creating conditions to enhance social bonding. Expanding opportunities, skills, and rewards for positive social involvement increase the likelihood that such youths become socially bonded. Researcher J. David Hawkins and his associates at the University of Washington suggest that youths that are bonded have a stake in society and feel connected to it. They have good reasons not to use alcohol, tobacco, and other drugs.

REFERENCE

Youth at High Risk for Substance Abuse (1990) BKD06

Social Marketing. Social marketing is defined as the design, implementation, and control of programs developed to influence the social acceptability of a social idea or cause by a group. It has its roots in both commercial marketing and social reform campaigns, such as the abolition of slavery and campaigns for government regulation of the quality of food and drugs.

While social marketing campaigns often rely on the use of mass media channels, it is more than mass media advertising. It involves identifying the needs of a specific group of people, supplying information so people can make informed decisions, offering programs or services that meet real needs, and assessing how well those needs were met.

Social marketing can be used in a range of situations to give information to the public or encourage specific target groups to take specific actions. For example, a familiar campaign to reduce drinking and driving problems focused its message not on the drinking driver, but on others with its "Friends Don't Let Friends Drink and Drive" slogan.

Using commercial marketing practices, social marketing makes the consumer, or in this case, the target audience, the focus of the program.

Marketing is the planned process of exercising influence on customer behavior. In the case of commercial product marketing the desired behavior is, of course, the purchase of the product being marketed. Social marketing is more complex, in that the product being promoted is more abstract, such as a change in behavior or belief to effect social change.

The following describes the differences between social marketing in the public health arena and product marketing campaigns:

- Type of change expected. Health campaigns aim to change fundamental behaviors, whereas much product advertising aims to mobilize an existing predisposition, as in switching brands. However, some product advertising does aim to create new markets.
- Amount of change expected. Health campaigns aim to change a large portion of the population. Product advertising is usually satisfied with small shifts in market share.
- Time frame of expected benefits. Health campaigns usually ask their target audience to wait for delayed statistical probabilities. Product advertisers promise immediate certainty.
- Presentation of the product. Product advertisers can dress up their product as much as they want or need to. Health campaigns do not, and probably cannot be seen to oversell benefits or the ease of their acquisition.
- Available budgets. Product advertisers have massive budgets. Health campaigners usually operate on relatively minuscule budgets.

- Trustworthiness. People often distrust advertising. Health campaigners cannot allow distrust to develop.
- Level of evaluation. Product advertisers stress formative research: market research conducted before campaigns. Health campaigners tend to stress summative evaluation, conducted after the campaign, if they stress any evaluation at all.

Prevention practitioners working to communicate messages to reduce alcohol, tobacco, and other drug problems have embraced techniques of social marketing, as well as media advocacy as part of an overall environmental approach to problem reduction. In a society with heavy reliance on mass media and a crowded message environment, the art of social marketing can make a valuable contribution to prevention efforts.

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- The Fact Is....Communications Programs Can Help Prevent Alcohol and Other Drug Problems* (1991) MS397
- Young Teens: Who They Are and How to Communicate with Them About Alcohol and Other Drugs* (1991) PH306
- Communicating About Alcohol and Other Drugs: Strategies for Reaching Populations at Risk. CSAP Prevention Monograph 5* (1992) BK170

Steroids. Some youths—eager to excel in athletics—reject alcohol, tobacco, and other drug use, yet use anabolic steroids with the hope of getting an edge as they strive for victory, popularity, and recognition. Student athletes often feel the pressure of participating in high visibility sports where one mistake can be the difference between winning and losing. The drive to excel at almost any cost can make steroid use appear to be an attractive option.

Anabolic steroids are synthetic hormones used by athletes to develop bulk and muscle strength. But their use can result in problems for athletes beyond the loss of medals. The physical and psychological risks of anabolic steroid use include:

- Damage to growth areas at the end of bones, permanently stunting growth;
- Weakened tendons, resulting in tearing or rupture;
- Facial hair, lower voice, and irregular menstrual periods for young women;
- Acne, loss of hair, and testicular shrinkage for young men;
- Infection with HIV through sharing needles to inject steroids;
- Depression, aggressiveness, or combativeness.

Anabolic steroids also cause legal problems. Problems associated with steroid use prompted legislation in 1989 making the nonmedical use and distribution of steroids a felony. As a result steroid use by athletes declined, but did not disappear.

Participation in sports and athletic activity is associated with physical performance and well being. As such, athletic programs are natural settings for alcohol, tobacco, and other drug prevention activities. Information on the adverse effects of alcohol, tobacco, and other drug use is readily integrated into training programs at schools and in other recreational settings.

Policies for participation in athletic programs can require participants to abstain from alcohol, tobacco, and other drug use. But it is important that all participants understand both the reasons for such a policy as well as the consequences for violation of the policy. And the policy must be enforced equitably.

Some student athletes still use steroids for what they see as a fast and easy road to success. Therefore, it is important for alcohol, tobacco, and other drug prevention activities in athletic settings to include information on steroid use as part of overall efforts. Including steroids in athletic policies lets young athletes know that there is a commitment to fair competition and intolerance of performance enhancing drugs to gain a winning edge.

REFERENCES

Performance Edge (1990) PE02
Anabolic Steroids: A Threat to Body and Mind (1991) PHD561
Steroids Don't Work Out! CSAP and American Academy of Orthopaedic Surgeons (1993)

Student Assistance Programs. Student assistance programs focus on behavior and performance at school, using a process to screen students for alcohol, tobacco, and other drug problems. They are modeled on employee assistance programs used at many workplaces. Student assistance programs represent a partnership between community health agencies and schools, and often rely on community agencies for assessment and treatment services.

Like their industry counterparts, some student assistance programs do not limit their activities to alcohol, tobacco, and other drug problems. Instead, they focus on identifying, referring, and assisting students with all issues causing problems that hinder a student's development.

The purpose of student assistance programs is to provide school staff with a mechanism for helping youth with a range of problems that may contribute to alcohol, tobacco, and other drug use. Teachers and other school staff receive training on how to identify youths experiencing problems. However, they are not expected to intervene personally. Students are referred to appropriate assessment and assistance resources.

Elements common to most student assistance programs include: early identification of student problems; referrals to designated helpers; in-school services, such as support groups and individual counseling; referral to outside agencies; and follow-up services.

Successful student assistance programs require the commitment of school boards, principals, and community members. This level of commitment, as well as appropriate training, provides school personnel with a valuable mechanism for helping students experiencing problems.

REFERENCES

- Prevention Plus II: Tools for Creating and Sustaining Drug-Free Communities* (1991)
Success Stories from Drug-Free Schools (1992) PHD588

Tobacco. According to the National Institute on Drug Abuse, in 1989 the proportion of high school seniors who were current smokers was 29 percent, with 18 percent of all seniors smoking daily. Neither the number of current smokers, nor the number of current daily smokers, is down significantly since 1984. Today more than 3 million youngsters under the age of 18 are regular smokers, and another 3 million experimenters are at high risk of addiction.

Studies document that most smokers acquire the habit as adolescents, with 80 to 90 percent of smokers starting before the age of 20, over 50 percent by age 18. Critics contend that, in this sense, children and youth are the cigarette industry's most important customers. *Stop Teenage Addiction to Tobacco* maintains that one of the key ways cigarette advertising increases smoking rates is by attracting children to become "replacement smokers for the more than 1,000 Americans who are killed every day by smoking-caused diseases."

The use of smokeless tobacco products by young people has risen in popularity. Tobacco-control advocates maintain that slogans such as "Take a pinch instead of a puff" and marketing campaigns that include free product samples and sports sponsorship contributed to an eight-fold increase in the use of moist snuff, a smokeless tobacco product, among 17- to 19-year-old males between 1970 and 1985.

Many of the marketing activities for smokeless tobacco products are tied in with sports, including professional rodeo, hunting, Indy car racing, including the Indianapolis 500, and monster truck, drag, and stock car racing. However, baseball is most often associated with smokeless tobacco.

The marketing strategies have been successful. Of the estimated 10 million American users of smokeless tobacco products, 3 million are under the age of 21. According to the 1990 Youth Risk Survey, 24 percent of all white male high school students currently use smokeless tobacco. The use of smokeless tobacco also rose 40 percent among college athletes from 1985 to 1989. In 1989 the National Collegiate Athletic Association reported that 57 percent of NCAA baseball players used smokeless tobacco products.

Efforts to eliminate smoking and use of smokeless tobacco by young people include smoking prevention programs in schools, increased public health education efforts, policies to reduce minor's access to tobacco products, availability of smoking cessation programs, and changes in tobacco advertising and pricing practices.

California's smoking control campaign has used mass media to reach teenagers to debunk the tobacco industry's ads linking smoking with social benefits. Tobacco ads are particularly strong in promoting the benefits of smoking in social settings and at parties, and in weight control. The mass media campaign includes a series of anti-smoking ads featuring an MTV-type character who interviews young smokers while wearing a gas mask. Other ads aimed at girls and young women depict what smoking can do to beauty. The idea behind the ads is to focus on the immediate consequences of smoking rather than long term health problems.

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- Youth and Drugs: Society's Mixed Messages. CSAP Prevention Monograph 6* (1990) BK172
- Alcohol, Tobacco, and Other Drugs Resource Guide on Tobacco* (1993) MS452
- "*Tobacco May Provide Gateway to Drug, Alcohol Abuse,*" *NIDA Notes* (1991)
- Smokeless Tobacco*. Tempe, AZ: Do It Now Foundation (1991)
- "Smoking Behavior of Adolescents Exposed to Cigarette Advertising," *Public Health Reports: Journal of the U.S. Public Health Service* 108(2):217-224, 1993

Violence. Alcohol and other drug use is associated with approximately 50 percent of spouse abuse cases, 49 percent of homicides, 38 percent of child abuse cases, and 52 percent of rapes.

Alcohol is the drug of choice in the United States. And it is the one most associated with violence. To a far greater extent than all other drugs combined, alcohol is associated with domestic violence, assault, homicide, and suicide.

But when we think about alcohol and other drugs in relationship to violence, we assume it is the user who becomes violent. However, many studies on alcohol, other drugs, and violence have to do with the "victim," not so much the perpetrator. The relationship between victim and perpetrator in terms of alcohol or other drug use is very complex. Pharmacological effects of alcohol and other drugs, personal expectancies, and cultural, environmental, and individual factors all are believed to contribute to a link with violent behaviors.

Violence associated with crack cocaine has turned many inner-city neighborhoods into war zones. Crack users commit crimes for money to buy the highly addictive drug and crack can induce violent behavior in users. But some studies have found that most drug-related violence involves disagreement over individual drug transactions or competition for territory among dealers.

Streets, homes, and schools are all affected by alcohol- and other drug-related violence. Early childhood injuries, abuse, or neglect; poor socialization experiences; lack of economic or educational opportunities; community disorganization; and physical reactions to specific types of drugs are factors often correlated with alcohol- and other drug-related violence.

While there are no easy answers to the complex problem of alcohol- and other drug-related violence, prevention programs that seek to respond to the broader social, economic, and environmental issues surrounding alcohol and other drug use are more likely to be effective in reducing violence.

REFERENCES

- Crack Cocaine: A Challenge for Prevention.* CSAP Prevention Monograph 9 (1991) BK190
- Drugs and Violence: Causes, Correlates, and Consequences.* NIDA Research Monograph 103 (1990) M103

Youth—Facts About Attitudes and Use.

Prevention must reach children long before they are faced with peer pressure to use drugs.

Preschool Youth

About 18 million children in the United States are under the age of 5. This age group is not too young for prevention programs specially designed for their level of understanding. Why should prevention focus on children so young? Youth experience pressure to use alcohol, tobacco, and other drugs at increasingly early ages. For example, a Weekly Reader National Survey on Drugs and Drinking noted that over half of sixth graders report peer pressure to drink beer, wine, or liquor, and one out of every three sixth graders say they feel pressured to use marijuana.

The home is the first place preschoolers can learn about prevention. Another place is in school settings. Over half of children ages 3 to 5 attend nursery school or kindergarten.

Prevention materials for parent- or teacher-directed use with preschoolers are in especially creative formats. CSAP's National Clearinghouse for Alcohol and Drug Information (NCADI) offers a prevention resource guide on preschool children that references prevention programs featuring puppets, dolls, coloring books, story books, posters, games, song cassettes, and stickers.

Elementary School Youth

The elementary school years are an especially critical time to reach youth because they are old enough to understand some adult issues, yet still young enough to be readily influenced by adults who care for them.

According to the Weekly Reader National Survey on Drugs and Drinking, children in grades two and three learn most of their information about the dangers of alcohol and other drugs from teachers, parents, and television. To aid parents in their prevention efforts, CSAP developed the publication, *10 Steps to Help Your Child Say "NO."* Briefly summarized, the 10 steps parents can take are the following:

1. *Talk with your child about alcohol, tobacco, and other drugs.* Parents can help change ideas children may have that "everybody" drinks, smokes, or uses other drugs.
2. *Learn to really listen to your child.* Children are more likely to talk when parents give verbal and nonverbal cues that show they are listening.
3. *Help your child feel good about himself or herself.* Children feel good when parents praise their efforts, as well as accomplishments, and when parents correct by criticizing the action rather than the child.
4. *Help your child develop strong values.* A strong value system can give children the courage to refuse rather than listening to friends.

5. *Be a good role model or example.* Parental habits and attitudes may strongly influence children's ideas about alcohol, tobacco, and other drugs.

6. *Help your child deal with peer pressure.* Children who have been taught to be gentle and loving may need parental permission to refuse negative peer pressure.

7. *Make family rules.* Parents can make specific family rules about children not using alcohol or other drugs or smoking cigarettes, with specific punishments for using them.

8. *Encourage healthy, creative activities.* A reasonable level of hobbies, school events, and other activities may prevent use out of boredom.

9. *Team up with other parents.* Parents can join their peers in support groups to reinforce the guidance they provide at home.

10. *Know what to do if you suspect a problem.* Parents can learn to recognize the telltale signs of alcohol, tobacco, and other drug use and get help immediately.

Pressure to use alcohol, tobacco, and marijuana usually begins during the elementary years. The Weekly Reader Survey reported that as early as the fourth grade, 40 percent of students feel pushed by friends to smoke cigarettes; 34 percent feel pressure to drink wine coolers; and 24 percent say their friends encourage them to try cocaine or crack.

Why do children use drugs? The same survey reported that children in the fourth, fifth, and sixth grades say they would be most likely to begin using beer, wine, or liquor to fit in with other youths and to feel older.

According to the NCADI publication, *Stopping Alcohol and Other Use Before It Starts*, grades five through nine are thought to be the most crucial time period for prevention programs. It is necessary to reach youths this early, or earlier, since almost one out of three boys and one out of five girls classify themselves as drinkers by age 13.

A resource guide on elementary children, materials developed especially for this age group, and publications for parents and teachers are available from NCADI without charge.

Secondary School Students

The United States has the highest rate of teenage drug use of any industrialized nation. More than one-third of all high school seniors say they engage in heavy drinking. Nearly half of high school students have used illicit drugs, with 48 percent of high school seniors reporting use of an illegal drug before graduating from high school.

Peers play a critical role in the initiation and continuation of alcohol, tobacco, and other drug use. While younger students (5th and 6th graders) would turn to parents if they had a personal problem with drugs, according to the Scholastic/CNN Newsroom Survey on Students Attitudes About

Drug and Substance Abuse, older students (11th and 12th graders) would turn to friends.

Peer pressure to use is intense during the high school years. Peers are known to have a powerful effect on an individual's use of alcohol, tobacco, or other drugs, and a high correlation has been established between an individual's use of alcohol, tobacco, and other drugs and that of his or her friends.

Peer pressure can also act as a powerful prevention tool. Many programs recruit students to participate in both the design and implementation of prevention activities. Student involvement can range from peer education to mentoring for students at risk for problems. Student assistance programs are based on the use of peer pressure as a positive force for shaping and reinforcing an environment that supports healthy choices by young people.

Drug availability in schools also has an impact on the number of students using alcohol, tobacco, and other drugs. If drugs are easily available in a school, there is a corresponding increase in the number of students using drugs, including alcohol. A recent study indicated that one-half of juniors and seniors said it would be easy to buy drugs while at school.

REFERENCES

- The Discovery Kit: Positive Connections for Kids* (1992) DISKIT
- Pointers for Parents* (1991) PH260
- Quick List: 10 Steps to Help Your Child Say "No"* (1990) PH230
- Learning to Live Drug Free: A Curriculum Model for Prevention* (1990) BKD51
- Prevention Resource Guide: Preschool Children* (1990) MS409
- Prevention Resource Guide: Elementary School Children* (1991) MS421
- Prevention Resource Guide: Secondary School Students* (1991) MS423
- Weekly Reader National Survey on Drugs and Alcohol*. Middletown, CT: Field Publications (1990)

Youth Participation. Young people want to be involved in decisions that affect their lives. And there is much to be gained from their participation in alcohol, tobacco, and other drug problem prevention activities, from planning to implementation. Involving young people helps to shift the responsibility for preventing alcohol, tobacco, and other drug problems away from professionals and agencies to the community, which is the best vehicle for implementing comprehensive prevention efforts.

True youth participation in prevention goes beyond asking one young person to sit on a community committee. It involves actively soliciting youths' involvement in problem identification and the design of activities and programs to reduce problems. Even young children have opinions about what needs to be done. Adults must not assume that they know what is best for youth, thus excluding them from full participation in developing community prevention initiatives.

Youth coalitions are one method of involving young people in community prevention efforts. Participation in such coalitions gives young people an opportunity to influence programs that directly affect them. Involving youth from the beginning ensures feelings of engagement as the programs develop and encourages leadership roles, in all their diverse forms. It also demonstrates that adults recognize young people as important members of society who can make worthwhile contributions.

Getting It Together: Promoting Drug-Free Communities describes four possible functions of youth coalitions as follows:

- *Information and resource sharing.* These coalitions serve as a clearinghouse of information for its members. They provide structure for information exchange on the latest technology, create forums for discussion, and develop a base for planning, education, and advocacy. Typical activities might include establishment of a resource center, sponsorship of conferences or seminars, and publication of a newsletter.
- *Technical assistance.* While similar to a resource-sharing group, these types of coalitions are somewhat narrower in focus. Their purpose is to effect positive change among group members by encouraging them to share expertise with one another or by combining resources to bring in outside expertise in an area of interest.
- *Planning and coordination of services.* Planning and coordination groups are outwardly focused. They may conduct community needs assessments, plan for future funding, or enlist greater community participation in prevention efforts.
- *Advocacy.* Coalitions of this type are designed to provide a unified voice in response to a specific situation or a more general issue. They may advocate for more resources or more political clout, lobby funding sources, or launch community awareness campaigns. For example, an advocacy coalition might ask a local recreation department for extended hours at a community center.

A key benefit of coalitions as a way to involve youth is their flexibility in both structure and purpose. They provide opportunities for young people of diverse backgrounds, interests, and skills to join together to address areas of mutual concern. Coalitions are more likely to be inclusive than exclusive by providing a range of roles and responsibilities to encourage involvement.

While developing successful coalitions require skillful organization and hard work on the part of youth organizations, they have the potential of involving young people in the exciting work of effecting great change in their communities.

REFERENCES

Getting It Together: Promoting Drug-Free Communities. A Resource Guide for Developing Effective Youth Coalitions (1991) PHD579

Prevention Plus II: Tools for Creating and Sustaining a Drug-Free Community (1991) BK159

Epilogue

Prevention Primer can be a useful reference tool for those who need a quick and easy source of current prevention information. However, its greatest asset—brevity—is also its greatest liability. Most readers will, at some time, need to delve deeper into subjects that are only touched upon in *Prevention Primer*.

When there is a need for more information, CSAP's National Clearinghouse for Alcohol and Drug Information (NCADI) can both provide prevention practitioners with the materials they need and refer them to appropriate organizations. NCADI was established by CSAP to be the Nation's "one-stop-information-shop" to provide public access to state-of-the-art alcohol, tobacco, and other drug prevention materials and information. To order NCADI's publications catalog or learn more about the subjects discussed in *Prevention Primer* write NCADI at P.O. Box 2345, Rockville, MD 20847-2345 or call 1-800-729-6686, TDD 1-800-487-4889.

As the prevention field evolves, as it surely will, CSAP may update *Prevention Primer* to ensure that the subjects and issues covered contain current information. Therefore, readers are encouraged to write to NCADI with ideas on how this publication can be improved and expanded to be even more helpful to both newcomers and seasoned prevention practitioners who want a quick, handy reference guide.

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